



DEPARTMENT OF VETERANS AFFAIRS
Medical Center
Post Office Box 592
Bay Pines, FL 33744

In Reply Refer To 119

Dear Applicant:

The residency applicant must possess a Doctor of Pharmacy Degree (Pharm.D.) from an ACPE-accredited school or college prior to entry in the residency program. Completion of a Pharmacy Practice Residency or equivalent is desired for the Primary Care Residency applicant. All residents will be required to successfully complete a state board examination obtained through any U.S. state board of pharmacy and are expected to sit for board licensure prior to beginning the residency program on July 1st and obtain board licensure by September 1st.

Residency application must include a letter of intent, transcripts, and three letters of recommendation from clinical practitioners who can evaluate your clinical skills as well as references, *Curriculum Vitae* and copy of your license if you have taken the pharmacy board exam at the time of application submission. After review of your completed application by residency faculty, eligible applicants will be invited for a mandatory onsite interview. Interviews in 2005 will be held on February 4th, 7th, or 11th.

The Pharmacy Practice Residency program participates fully in the American Society of Health System Pharmacist Matching Program. All processing will be according to the terms and schedule of dates of the ASHP matching program. Please contact ASHP or visit the National Matching Program website at www.natmatch.com/ashprmp for more information. The specialty residency programs do not participate in the matching program.

Thank you for your interest and contact us for any questions you may have on the residency programs,

Carolyn Stephens, Pharm.D.
Residency Director
(727) 398-6661, ext 7974
Carolyn.Stephens@med.va.gov

**RESIDENCY PROGRAM APPLICATION
BAY PINES VA MEDICAL CENTER
BAY PINES, FL 33744**

Applicant:

First Name

MI

Last

E-mail

Present Address:

Street Address or P.O. Box

State

Zip

Phone

Permanent Address:

Street Address or P.O. Box

State

Zip

Phone

Residency Program:

(Check one)

- Pharmacy Practice
 Ambulatory/Primary Care
 Infectious Diseases

The following items must be received to complete this application:

? Discussion of your professional goals
and objectives (one page, typed)

? A current *Curriculum Vitae*

? Copies of official transcripts from
all colleges of pharmacy attended

? Three (3) letters of recommendation from
professional practitioner/clinical faculty
(Must be mailed confidentially)

Licensure/Citizenship

Are you licensed to practice pharmacy in the United States? Yes No

If so, in what state? _____ Year Licensed: _____ License # _____
(Or expected state and date of licensure)

Are you a United States citizen? Yes No

Education

Pharmacy School: _____

Degree (s) _____ Date of Graduation: _____

Degree (s) _____ Date of Graduation: _____

Other College (s) _____

Degree (s) _____ Date of Graduation: _____

Please answer the following questions in the space provided below (typed or printed) or on a separate sheet

How will this residency help you achieve your professional goals?

How will your past accomplishments/achievements help you during your residency?

Discuss some aspect of direct patient pharmaceutical care where you feel you had a vested, personal interest in the patient's outcome.

How do you feel about the following required activities of the pharmacy residency:

Inservices:

Staffing:

Research Project:

Precepting Students:

Hobbies or special interest that attract you to this (St. Petersburg) area?

Signature: _____

Complete, sign, and return this form and all application materials by January 10th to allow for final review and on-site interview. Please send to:

Carolyn Stephens, Pharm.D.,
Residency Director
P.O. Box 592
Bay Pines, Florida 33744



RECOMMENDATION REQUEST
Pharmacy Residency Program
Bay Pines, Florida 33744

To be completed by applicant: (Please print or type)

Name of Applicant:

First Name	MI	Last Name
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Street Address or P.O. Box

City	State	Zip	Phone	E-mail
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I waive the right to review this recommendation.

Signature of Residency Applicant

Applicants to the residency program specified above are required to have recommendations submitted by persons who are in a position to evaluate their qualifications for residency training. The recommender is asked to make a frank appraisal of the applicant's character, personality, abilities, and suitability for a pharmacy residency. **All comments and information provided will be kept in strictest confidence.**

Recommender to complete the following:

I have known the applicant for approximately _____ months/years.

My relationship to the applicant was (or is) in the following capacity:

- Faculty advisor Clerkship preceptor Other faculty relationship Other

I have know him/her: Very well Fairly well Only casually

Relative to persons of **similar background, training, and professional interests**, how would you rate this applicant for each of the following characteristics? Place an X under the rating column which best describes the applicant.

Characteristics Evaluated	Upper 10%	Upper 25%	Upper 50%	Lower	No Basis
Academic ability					
Quality of work					

Written communication skills					
Leadership skills					
Oral communication skills					
Industriousness and perseverance					
Initiative and motivation					
Assertiveness					
Cooperativeness					
Ability to organize and manage time					
Ability to work with supervisors					
Ability to work with peers					
Ability to work with patients					
Dependability					
Resourcefulness and originality					
Acceptance of constructive criticism					
Appearance and professional demeanor					
Commitment to professional practice					
Emotional stability and maturity					
Enthusiasm					
Integrity					
Research skills					

Does the applicant possess any special assets which should be noted?

Does the applicant demonstrate any weakness which you feel would hinder his/her ability to perform effectively in a residency program?

Please comment on the applicant's ability to engage in research activities.

Other comments:

Recommendation concerning admission (check one):

I highly recommend this applicant. I recommend this applicant, but with some reservation.

I recommend this applicant.

I am not able to recommend this applicant.

Signature of Recommender/Date

Name (Typed or Printed)

Title and Affiliation

Street Address or P.O. Box

City State Zip

Telephone Number

Please complete and return this form by January 10th to:

Carolyn Stephens, Pharm.D.
Residency Director
P.O. Box 592
Bay Pines, Florida 33744