

PGY1 Pharmacy Practice Residency Program Application

Applicant Information:

Name (Last, First, MI): _____

Are you known by any other name? _____ () Preferred

Indicate which address to send correspondence:

Permanent Address: _____

City: _____ State: _____ Zip: _____

Current Address: _____

City: _____ State: _____ Zip: _____

I will be at this current address until: _____

Current home phone no.: _____ Permanent phone no.: _____

E-mail: _____ Cell phone: _____

Preferred method of contact: (choose one) () Email () Mail

Date of Birth: ____/____/____ (Optional)

Are you eligible for licensure in South Carolina () Yes () No

If No please explain: _____

Most recent cumulative pharmacy GPA: _____

ASHP Residency Matching Program Number : _____

(Enrollment in Match Program is required)

For identification purposes only, we would appreciate a recent photograph:

() Picture Enclosed () Decline

Academic History:

List colleges/universities attended, dates and degree earned beginning with most recent degree.

Institution	Location	Dates of Attendance	Degree

Professional Experiences:

List, beginning with most recent, your experience record in pharmacy practice.

Institution/Place of Employment	Location (city, state)	Dates of employment	Position held

Professional Recommendations:

Please list three individuals from whom we may expect letters of reference on your behalf. Letters of reference may be mailed separately, but must be **received** by the application deadline, **January 15th**.

1. Name: _____
 Title: _____
 Address: _____
 Phone: _____ Email: _____

2. Name: _____
 Title: _____
 Address: _____
 Phone: _____ Email: _____

3. Name: _____
 Title: _____
 Address: _____
 Phone: _____ Email: _____

I certify that the information in this application is accurate and that McLeod Regional Medical Center Department of Pharmacy Services may obtain and use this information in their evaluation of my application. I grant permission, if necessary, to request additional information from previous schools and employers.

Signature

Date

In order for your application to be considered complete, all of the following **must be received by January 15th**.

- Copy of this residency application form
- Copy of your current curriculum vitae
- Copy of your pharmacy school transcript(s)
- Three (3) letters of recommendation emailed or mailed to the address below and (3) completed recommendation forms (see website).
- A personal statement outlining your reasons for desiring this residency. Include your future professional plans and residency expectations.



Please send all application materials to:

Bradley White, Pharm.D.
McLeod Regional Medical Center
Department of Pharmacy
555 East Cheves Street
P.O. Box 100551
Florence, South Carolina 29501
bwhite@mcleodhealth.org

To be completed by pharmacy office staff:

Application received by: _____

Date: _____