

FELLOWSHIP APPLICATION
AMERICAN COLLEGE OF CLINICAL PHARMACY

INTRODUCTION

Fellowship in the American College of Clinical Pharmacy (FCCP) is one means by which the College can foster and reward demonstrated excellence in the practice and science of clinical pharmacy. Fellowship is awarded to individuals who have made a sustained contribution to the College and demonstrated a continued high level of excellence in clinical pharmacy practice and/or research.

To be eligible for consideration, an applicant must have must have been a Full Member of ACCP for at least five (5) years prior to the year of Fellowship induction and have been practicing clinical pharmacy for at least ten (10) years since receipt of his/her highest professional practice degree (i.e., B.S. or Pharm.D.).

INSTRUCTIONS

1. **PLEASE COMPLETE ALL INFORMATION REQUESTED.** The purpose of this form is to establish an objective basis whereby nominees for Fellow can be evaluated on the basis of ACCP's definition of Clinical Pharmacy. Each application is reviewed and scored by members of the Credentials: Fellowship Committee, which recommends to the Board of Regents whether an applicant should be elected as a Fellow based on his/her sustained contributions to the College and continuous high level of excellence in clinical pharmacy practice and/or research

The Credentials: Fellowship Committee will base its scoring solely on the information supplied in this application. The applicant's *Curriculum Vita* (CV) is used as a reference document for selected sections of the application and to assist with the committee's global assessment of the applicant's qualifications for ACCP Fellow. To be successful, the applicant must take the time to thoroughly and thoughtfully complete this application. It has been the experience of the Credentials: Fellowship Committee that worthy FCCP candidates have been unsuccessful due to their failure to submit a complete application form. Although it is not necessary to provide a positive response for every item, it is in the applicant's best interest to respond to as many questions as appropriate in order to assure a complete and fair review. Descriptions should be specific and detailed. The information provided may describe both past and present activities. Please do not simply state, "refer to CV" when providing the information requested.

Also enclosed with this application is a copy of the primary scoring criteria and guidelines ("Fellow Tally Sheet") that will be used by the committee in completing its review. Note that additional criteria can be applied as well. The primary criteria are provided so applicants are fully aware of the guidelines used in electing Fellows and so they can make an informed self-assessment to determine whether or not to proceed with the application process. *Every applicant is strongly encouraged to perform a self-assessment before deciding to submit this application.*

2. **Please include a copy of your Curriculum Vitae.**
3. **E-mail your application and CV by APRIL 15, 2010 to:**

Michael S. Maddux, Pharm.D., FCCP
Executive Director
mmaddux@accp.com

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AMERICAN COLLEGE OF CLINICAL PHARMACY

NAME: _____ DATE: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

E-MAIL: _____

SUSTAINED CONTRIBUTIONS TO ACCP

1. Highest pharmacy professional degree (e.g., Pharm.D., B.S.):_____. Year received:_____

2. Year in which you became a full Member of ACCP:_____

3. Please list presentations made at ACCP-sponsored meetings (as a primary or senior author on posters/platforms, or as a presenter of an educational session). No points are awarded for moderating a session. (Add more rows by pressing “Tab” at the end if more space is needed.)

Date (mo/dd/yr)	Meeting/Symposium	Title of Presentation

4. Please list: a) your membership on all ACCP national standing or ad-hoc committees, PRN committees, or chapter committees (identify those for which you served as chairman with an asterisk [*]), and b) service as a Regional Recruiter or College of Pharmacy Liaison. (Add more rows by pressing “Tab” at the end if more space is needed.)

Date (mo/dd/yr)	Committee or Service

CLINICAL PHARMACY PRACTICE AND RESEARCH

Clinical Pharmacy Service Programs

1. Please describe any clinical pharmacy service programs that you have developed and implemented (include dates and locations). Please be certain to emphasize how this program is (or was) unique and/or innovative. For example, it would be worthwhile to note that it was the first such service nationally. Please specify also, when it was implemented, whether it has been transferred or copied elsewhere, whether it has been evaluated in some way, and whether that evaluation has been published in the professional literature. Please include a brief description of your role(s) in this service. Awards for service contributions may also be described here. (Add more rows by pressing “Tab” at the end if more space is needed. Please note that the right-most column is reserved for reviewer use.)

Clinical Pharmacy Service						
Date/Location	Program	Description	Impact	Evaluation	Role(s)	*

*** Please leave blank. For reviewer use only.**

Patient Education Service Programs

2. Please describe any patient education programs, designed to improve patient understanding of, and adherence to, prescribed drug therapy that you have developed and implemented (include dates and locations). Please be certain to emphasize how this program is (or was) unique and innovative. For example, it would be worthwhile to note that it was the first such service nationally. Please specify also, when it was implemented, whether it has been transferred or copied elsewhere, whether it has been evaluated in some way, and whether that evaluation has been published in the professional literature. Please include a brief description of your role(s) in this service. . (Add more rows by pressing “Tab” at the end if more space is needed. Please note that the right-most column is reserved for reviewer use.)

Patient Education Service						
Date/Location	Program	Description	Impact	Evaluation	Role(s)	*

* Please leave blank. For reviewer use only.

3. Please describe any certifications, other credentials, or other activities that document your clinical practice competencies. Examples could include board certification in Pharmacotherapy or other BPS-recognized specialties, documentation of competency from other professional organizations (e.g., Certified Diabetes Educator, BLS, ACLS certification, lipid or anticoagulation certification, etc.), or local credentialing/privileging processes in your institution/organization. (Add more rows by pressing “Tab” at the end if more space is needed. Please note that the right-most column is reserved for reviewer use.)

Certifications, Credentialing, and Other Activities to Document Clinical Practice Competencies		
Date(s)	Organization/Institution and Credential/Activity	*

* Please leave blank. For reviewer use only.

4. If you currently function, or have functioned in the past, as a clinician that initiates and monitors individual patients' acute or chronic drug therapy (either through a collaborative drug therapy management practice agreement or otherwise), please describe this activity in detail (e.g., hypertension clinic, anticoagulation clinic, inpatient services). When therapeutic protocols are used, describe the procedure for and your contribution to their development and implementation. (Add more rows by pressing "Tab" at the end if more space is needed. Please note that the right-most column is reserved for reviewer use.)

Initiation and Monitoring of Acute or Chronic Drug Therapy					
Date(s)	Practice Settings	Description of Activities	Development and Implementation of Therapeutic Protocols (if Applicable)	Prescriptive Authority Delegated to You? (Yes/No)	*

* Please leave blank. For reviewer use only.

5. Please list up to 15 examples of different educational or professional presentations that you have made to state, national, or international pharmacy or other health discipline meetings. Please do not identify presentations of original research in this section. More weight is given to presentations at national/international meetings. Include only presentations that you delivered in person. (Add more rows by pressing “Tab” at the end if more space is needed. Please note that the right-most column is reserved for reviewer use.)

Educational or Professional Presentations (Non-Research)				
Date	Title of Presentation	Meeting	Indicate State (S) , Natl (N), Intl (I)	
				*

* Please leave blank. For reviewer use only.

6. Please list up to 15 different examples of scientific research presentations (e.g., results of original research in applied/clinical pharmacology, pharmacokinetics, pharmacotherapeutics, or clinical pharmacy practice) which you have made to state, national, or international pharmacy or other health/scientific discipline meetings. Priority is given to presentations at national/international meetings. Include only presentations that you have delivered in person. (Add more rows by pressing “Tab” at the end if more space is needed. Please note that the right-most column is reserved for reviewer use.)

Research Presentations				
Date	Title of Presentation	Meeting	Indicate State (S) , Natl (N), Intl (I)	
				*

* Please leave blank. For reviewer use only.

11. Please list those professional or scientific publications for which you currently serve (or previously served) as a referee, member of the editorial board, or editor. List only National or International publications; omit local and state or regional publications.

Service to Publications				
Publication	Check Appropriate Category			
	Referee	Editorial Board	Editor	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*
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* Please leave blank. For reviewer use only

13. Please identify any leadership positions (i.e., elected office, committee membership) you have held in professional associations other than ACCP. Also indicate your participation in any political advocacy efforts/initiatives (including the ACCP Advocates), noting any leadership roles in these efforts. Please designate each organization and effort/initiative as either national (N) or state (S). (Add more rows by pressing “Tab” at the end if more space is needed. Please note that the right-most column is reserved for reviewer use.)

Leadership Positions				
Date(s)	Office/Role	Professional Association (other than ACCP) or Political Advocacy Group (ACCP or non-ACCP)	National or State	
				*

* Please leave blank. For reviewer use only

14. Please use this space, if desired, to describe any other unique contributions you have made to the profession that you would like to bring to the attention of the Committee and that are not reflected above.