University of Georgia College of Pharmacy
PGY-1 Pharmacy Hospital Practice Residency Application

NAME: **ASHP Match Code:**

Last, First M.I.

Current Address **Telephone:**

Street Apt.

Cell:

City State Zip Code

E-mail:

Date of Birth: **Birthplace:** **Citizenship:**

Educational History

Names of all colleges and/or professional schools attended	Location	Dates Attended From / To	If graduated give date	Degree and/or major field of study

Pharmacy Related Work Experience

Position	**Employer**	**Dates Employed**	**Reason for leaving**
	Name	From:	
	Address	To:	
	Name	From:	
	Address	To:	
	Name	From:	
	Address	To:	

Licensure Status

Are you currently licensed to practice pharmacy?

If no, are you eligible for Georgia licensure?

Complete Information Below (if applicable)

State	Certificate Number	Date Granted

List specific areas of interest in pharmacy:

All required application materials, listed below, must be electronically submitted on PhORCAS:
https://portal.phorcas.org/

1. **This completed application form**.
2. **Letter of intent** stating reasons for pursuing a Pharmacy Hospital Practice Residency, and how this program will meet your needs.
3. Updated **curriculum vitae**
4. **Three letters of reference.** The letters must be uploaded on PhORCAS by each individual reference. Letters from preceptors, faculty and practitioners are preferred.
5. Official copy of college of pharmacy/university **transcripts.**

Application Deadline: **February 1**

The University of Georgia, College of Pharmacy is an equal opportunity employer and does not discriminate on the basis of race, religion, sex, age, national origin or disability.

I certify that I hold a pharmacist license and am in good standing with the respective Board of Pharmacy. Furthermore, I certify that the responses on this application form and all accompanying materials are true to the best of my knowledge, and I am aware that any knowing falsification heron may result in denial of acceptance or continuation in the residency program.

NOTICE: By submitting this document online to **PhORCAS**, you are certifying and agreeing to the above.

Name: Date:

Program Director: Rod Gilmore, R.Ph., BSPharm

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