SAVE AS CLEAR PRINT

UNIVERSITY OF GEORGIA
College of Pharmacy
Clinical & Administrative Pharmacy

PHOEBE PUTNEY MEMORIAL HOSPITAL

PGY-1 Pharmacy 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 Address	From: To:	
	Name Address	From: To:	
	Name Address	From: 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: **January 5th**

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 am in good standing with the respective Board of Pharmacy, and am eligible for licensure in the State of Georgia. 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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Albany, Georgia 31701
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