HIV PGY2 Pharmacotherapy APPLICATION

Name:
Street Address:
City: **State**: **ZIP**:
Country:
Preferred Phone:
Email:
SSN (Last 4 digits):

Education:

College:

Degree: **Date**

College:

Degree: **Date**

License Information:

License State: **License Number**: **Type**

Employment Record:

1.Employer Name:

Address:

Position Title: **Date of Employment**:

Duties:

Supervisor name and contact information:

2.Employer name:

Address:

Position Title: **Date of Employment**:

Duties:

Supervisor name and contact information:

References:

NAME	TITLE	Contact information
1.		
2.		
3.		

What do you hope to gain from the clinical components of our HIV residency?

What aspects of the University of Illinois at Chicago program do you find particularly appealing and pertinent to your individual goals?

What aspects of the University of Illinois at Chicago program do you find inconsistent with your individual goals?

Application Certification:

I certify that all of the information submitted by me in this application is true to the best of my knowledge and belief. I understand that any significant misstatement in, or omission from, this application may be cause for denial of selection as a resident or dismissal from a residency position. I authorize the residency site to consult with persons and institutions with which I have been associated who may have information bearing on my professional competence, character, and ethical qualifications now or in the future. I release from liability all residency staff for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I also release from liability all individuals and organizations that provide information to the residency site in good faith and without malice concerning my professional competence, ethics, character, and other qualifications now or in the future.

I further understand that it is my responsibility to inform the residency sites to which I have applied if a change in my status with my academic program, (e.g., being placed on probation, being dismissed, etc.) occurs subsequent to the submission of my application. In addition, I understand I have the same responsibility to inform the residency site if a change in status has occurred.

I understand and agree that, as an applicant for the pharmacy residency program, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

Applicant Signature:_____

Signature Date:_____