## Pharmacists Clinical Experience Program Application

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| Applicant | | | |
| Name: |  | | |
| Home Address: |  | | |
| Place of Employment: | |  | |
| Work Address | |  | |
|  | | | |
| Mentor | | | |
|  | | | |
| Name of Mentor | | Place of Employment / Host Institution & Address | |
|  | |  | |
| Description of Practice Site: | |  | |
| Past Mentor/Preceptor Experience (if not included in CV) | |  | |
| Program Information | | | |
|  | | | |
| Area of Interest (clinical, administrative or research): | | |  |
| Goal(s) of the Program: | | | |
|  | | | |
| Objectives of the Program (Include specific learning objectives, overview of applicant’s current practice site, impact of the program on applicant’s current practice, planned activities): | | | |
|  | | | |
| In the case of a research project, please provide project details: | | | |
|  | | | |
| Plan for applying acquired knowledge (how will this program help identify and resolve gaps in current practice, improve your current practice): | | | |
|  | | | |
| Proposed Budget | | | |
| Travel:  Meals:  Accommodation:  Honoraria:  Licensing/Liability Insurance:  Miscellaneous (specify): | | | |
| **Additional Supporting Material** | | | |
| Application Form  Curriculum Vitae and cover letter of applicant (detail CSHP involvement, if applicable)  Curriculum Vitae of Mentor  Letter of agreement/support from applicant’s employer/supervisor/manager/director  Letter agreeing to support program from host institution (Director of Pharmacy or equivalent)  Other letters of support (optional) | | | |
| Signatures | | | |
| Applicant:  Mentor: | | | Date:  Date: |

By signing this form, we, the applicant and mentor, agree to dedicate the time required to achieve the goals and objectives specified above.

I, the applicant, assume all responsibility for organizing and paying for all components of the program (travel, lodging, meals, professional liability insurance {if required}, payment of honorarium/stipend, etc.)

**Forward application by April 28, 2017 via email to**:

Andrea.Meade@nshealth.ca or [Michelle.tenBrinke@nshealth.ca](mailto:Michelle.tenBrinke@nshealth.ca) **or via fax to**

Andrea Meade

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Phone: (902) 465-8556

Fax: (902) 465-8548 (if faxed, please confirm with email)