## Pharmacist Clinical Experience Program Application

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| Applicant | | | | | | | |
| Name: | |  | | | | | |
| Email: | |  | | | | | |
| Phone: | |  | | | | | |
| Place of Employment & Address: | |  | | | | | |
| Mentor | | | | | | | |
| Mentor’s Name: | | | |  | | | |
| Mentor’s Email: | | | |  | | | |
| 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 (include an overview of your current practice site; describe the positive impact you hope this program will have): | | | | | | | |
|  | | | | | | | |
| Objective(s) of the program (include specific learning objectives, planned activities): | | | | | | | |
|  | | | | | | | |
| Plan for applying acquired knowledge (include specific steps you plan to take; describe which gaps will be resolved/improved in your own practice and/or your institution): | | | | | | | |
|  | | | | | | | |
| In the case of a research project, please provide project details: | | | | | | | |
|  | | | | | | | |
| Proposed Budget | | | | | | | |
| Travel: | | |  | | | | |
| Meals: | | |  | | | | |
| Accommodation: | | |  | | | | |
| Honoraria: | | |  | | | | |
| Licensing/Liability Insurance: | | |  | | | | |
| Miscellaneous (specify): | | |  | | | | |
| **Additional Supporting Material** | | | | | | | |
| 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:  Date: | .        . | | | | | Mentor:  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 completed application by June 30, 2022 via email to**: [nada.toulany@nshealth.ca](mailto:nada.toulany@nshealth.ca)