

# Application Form

## Washington State University-Affiliated Residency Program

### Residency in Pharmacy Practice

#### Yakima Valley Memorial Hospital, Yakima WA

*Application must be completed by January 15. A letter of intent, stating your career goals, major areas of interest, and reasons for applying to this program must be attached to your application form.*

Name \_\_\_\_\_

Please Print – Last, First, Middle

Please indicate which address you would like correspondence sent to during the recruitment process.

**Permanent Address**

**Temporary Address**

\_\_\_\_\_  
Street, Apt. #

\_\_\_\_\_  
Street, Apt. #

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

Phone: Daytime \_\_\_\_\_

Phone: Daytime \_\_\_\_\_

Message \_\_\_\_\_

Message \_\_\_\_\_

Social Security Number \_\_\_\_\_

ASHP Match Number \_\_\_\_\_

State(s) Licensed to Practice \_\_\_\_\_

#### List of Colleges/Universities Attended:

◆ Name of College/University: \_\_\_\_\_

Dates \_\_\_\_\_ Degree \_\_\_\_\_

◆ Name of College/University: \_\_\_\_\_

Dates \_\_\_\_\_ Degree \_\_\_\_\_

◆ Name of College/University: \_\_\_\_\_

Dates \_\_\_\_\_ Degree \_\_\_\_\_

Letters of reference are required from three health care professionals who can attest to your practice abilities and aptitudes. List names, addresses and telephone numbers of references below:

■ \_\_\_\_\_

■ \_\_\_\_\_

■ \_\_\_\_\_

Are you prevented from becoming lawfully employed in the United States because of visa or immigration status?  Yes  No

If you are appointed to the residency program, you will need to show documentation providing identity information and employment authorization for the entire period of the residency.

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**Application Requirements:**

- Completed application form
- Letter of intent stating goals and interests
- Curriculum Vitae
- Official transcripts of all professional pharmacy education
- Three references from health care professionals

Transcripts and references should be sent under separate cover to the address listed below.

Application deadline: January 15.

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I certify that the information submitted in this application is complete and correct to the best of my knowledge and belief. I grant Washington State University permission to request additional information, if necessary, from previous schools and employers concerning my academic records and professional ability.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Send application materials to:**

**Angela S. Stewart, Pharm.D., BCPS  
Residency Program Director  
Yakima Valley Memorial Hospital  
Department of Pharmacy  
2811 Tieton Drive  
Yakima, WA 98902  
509-577-5070  
Angela.Stewart@yvmh.org**

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# Letter of Recommendation

## Recommendation Request for Pharmacy Residency Applicant Washington State University-Affiliated Residency

### Applicant

**Name:** \_\_\_\_\_  
(Print: First, MI, Last)

**Address:** \_\_\_\_\_  
(Street, Apt. #)  
\_\_\_\_\_  
(City, State, Zip Code)

**Telephone:** ( ) \_\_\_\_\_

### Reference

**Name:** \_\_\_\_\_  
(Print: First, MI, Last)

**Title:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City, State, Zip Code)

### **Applicant:**

I waive the right to review this recommendation. \_\_\_\_\_

**Please complete by January 31<sup>st</sup>. If you prefer to write a letter in addition to this form, please attach.**

◆ How well and in what capacity do you know the applicant?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

◆ What special strengths do you feel the applicant possesses that should be noted?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

◆ What weaknesses do you feel the applicant possesses that should be noted?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please rank the applicant on the following traits in comparison with others at the same level of experience and training. Circle appropriate rank or if unable to comment leave blank.  
 (1 = unsatisfactory, 5 = exceptional)

	Unsatisfactory		Satisfactory		Exceptional
Ability to communicate effectively	1	2	3	4	5
Ability to express self in writing	1	2	3	4	5
Ability to organize work/establish priorities	1	2	3	4	5
Ability to work and cooperate with others	1	2	3	4	5
Clinical skills	1	2	3	4	5
Distribution skills	1	2	3	4	5
Intellectual skills	1	2	3	4	5
Ability to provide leadership	1	2	3	4	5
Motivation	1	2	3	4	5
Originality/Creativity	1	2	3	4	5
Teaching skills	1	2	3	4	5

**Additional Comments:**

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Recommendation for acceptance into the residency (check one):

- The applicant has my highest recommendation
- I recommend the applicant with confidence
- I recommend the applicant with some reservation
- I am unable to recommend this applicant

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We encourage you to provide any additional information that you feel may be helpful in our selection process. This form and any additional information should be submitted no later than January 31<sup>st</sup>.

**Angela S. Stewart, Pharm.D., BCPS**  
**Residency Program Director**  
**Yakima Valley Memorial Hospital**  
**Department of Pharmacy**  
**2811 Tieton Drive**  
**Yakima, WA 98902**  
**509-577-5070**  
**Angela.Stewart@yvmh.org**