

APPLICATION PROCESS

- ❑ Formal letter of application
- ❑ Current curriculum vitae
- ❑ Three letters of reference
 - Two of which should be from clinical pharmacy practitioners who have worked directly with the applicant
 - Recommendation request forms enclosed
- ❑ Transcripts from both pre-pharmacy and pharmacy programs
- ❑ Completion of residency application (application enclosed)
 - Indicate the program to which you are applying
- ❑ Completion of an online employee application at www.e-baptisthealth.com
- ❑ Recent photograph
- ❑ ASHP Match Number
- ❑ To Register for ASHP Resident Matching Program, applicants can obtain an Applicant Agreement by
 - Downloading the Agreement from the website: www.natmatch.com/ashprmp.
 - Completing and submitting a form available on the website to request an Applicant Agreement be sent to you by regular mail.
 - Completing the enclosed form requesting an Applicant Agreement be sent to you by mail.
- ❑ Application deadline: January 10th
- ❑ Residency Application and Recommendation Request forms are also available at www.e-baptisthealth.com/pharmacyresidency

- ❑ Wolfson Children's Hospital/Baptist Health ASHP Match Numbers
 - **PGY1: 125421**

 - **PGY1 emphasis in Pediatrics: 125413**

- ❑ Send your completed application packet to:
Bryan Blackwelder, Pharm.D.
Residency Program Director, Pediatric Clinical Coordinator
Baptist Medical Center
Department of Pharmacy
800 Prudential Drive
Jacksonville, FL 32207
904-202-2853
pharmacyresidency@bmcjax.com

**BAPTIST HEALTH/WOLFSON CHILDREN'S HOSPITAL
PGY1 RESIDENCY APPLICATION**

Please complete this form and return with your application packet. You must complete the online application at e-baptisthealth.com.

Application Deadline --- January 10th

Please select the program to which you are applying.

PGY1 PGY1 emphasis in pediatrics

Last Name First Name Middle/Maiden

Street address or P.O. Box

City State Zip

Cell Phone Home Phone

Email

ASHP Match Number

Please attach a recent passport style photograph. This photograph is for identification and interview purposes only. Please write your name and ASHP match number on the back of your photograph.

*Attach
Photo
Here*

BAPTIST HEALTH/WOLFSON CHILDREN'S HOSPITAL

PGY1 RESIDENCY RECOMMENDATION REQUEST

To be completed by applicant (Please print or type) Name of Applicant:

Last Name	First Name	Middle/Maiden	
Street Address or P.O. Box			
City	State	Zip	Telephone

I waive the right to review this recommendation. _____
Signature of Residency Applicant

To be completed by recommender:

Applicants to our residency program are required to have letters of recommendation submitted by persons who are in a position to evaluate their qualifications for residency training. The recommender is asked to make an honest appraisal of the applicant's character, personality, abilities, and suitability for a pharmacy residency. All comments and information provided will be kept in strict confidence.

Please submit a letter of recommendation attached to this form and rate the applicant's abilities on the form provided. In your reference letter please provide the following information, if possible, as well as any other information you feel is pertinent to this student's application.

- | | |
|---|---|
| How long have you known the applicant and in what capacity
Ability to work with others
Applicant's strengths and weaknesses
Your recommendation on the applicant's candidacy | Time management and organizational skills
Reliability and dependability
Initiative and motivation
Communication skills |
|---|---|

Signature of Recommender	Institution/Company
Typed or printed name and title	Street Address or P. O. Box
Position/Title	E-mail Address
Telephone	Fax

Recommendation request form (2 pages) and letter of recommendation must *be received by January 10th*. The letter of recommendation may initially be sent by e-mail with a hard copy to immediately follow. Send materials to:

Bryan Blackwelder, PharmD
Pediatric Clinical Coordinator, Residency Director
Baptist Medical Center
Department of Pharmacy
800 Prudential Drive
Jacksonville, FL 32207
Fax (904) 202-3142
pharmacyresidency@bmcjax.com

BAPTIST HEALTH/WOLFSON CHILDREN'S HOSPITAL

PGY1 RESIDENCY RECOMMENDATION REQUEST

To be completed by applicant (Please print or type) Name of Applicant:

Last Name First Name Middle/Maiden

To be completed by recommender:

Relative to persons of similar background, training, and professional interests, how would you rate this applicant for each of the following characteristics? Please place an X under the rating column which best describes the applicant.

CHARACTERISTICS EVALUATED	UPPER 10%	UPPER 25%	UPPER 50%	LOWER 50%	NO BASIS FOR JUDGEMENT
Academic ability					
Quality of work					
Written communication skills					
Oral communication skills					
Leadership skills					
Industriousness and perseverance					
Initiative and motivation					
Assertiveness					
Cooperatives					
Ability to organize and manage time					
Ability to work with supervisors					
Ability to work with patients					
Dependability					
Resourcefulness and originality					
Willingness to accept constructive criticism					
Personal appearance and professional demeanor					
Commitment to professional practice					
Emotional stability and maturity					
Enthusiasm					
Integrity					

Please attach this form to your letter of recommendation.

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