

APPLICATION INSTRUCTIONS

College of Pharmacy
The University of Texas at Austin
and
Affiliated Institutions
in Austin, El Paso, Rio Grande Valley, San Antonio and Temple

- A. Provide an official transcript of your academic work, Curriculum Vitae and three (3) letters of recommendation from those individuals who have first hand knowledge of your performance as a clinician, teacher or researcher. Please have these letters addressed to the following address. You may be applying to multiple sites and be asked to provide letters, transcripts, applications, etc. to these individual sites as well, but we **MUST** receive application, letters of recommendation & transcript to the address below.

Postdoctoral Training Committee
ATTN: Dr. William McIntyre
Pharmacotherapy Education & Research Center
University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive - MSC 6220
San Antonio, Texas 78229-3900

- *1. The date on which the Residency/Fellowship commences normally is July 1 of each year, however, some flexibility in the reporting date exists. (Note: Fellows will be expected to make a two-year commitment to research, teaching and clinical practice at this institution.
- 2-13. Self-explanatory.
14. This information is used for statistical purposes. Candidate selection is determined without regard to ethnic background.
15. The information provided should account for all your time since graduation from high school.
16. RESIDENTS / M.S. PROGRAM: Please indicate the area of specialization in which you wish to continue your clinical training.
17. FELLOWS / M.S. PROGRAM and PH.D. APPLICANTS: If you have special research interests which you would like to pursue at this institution this information will help us determine the availability of appropriate opportunities.
18. FELLOWS: The continuing development of clinical knowledge and skills is included with research training in the fellowship program. Please specify the area where you wish to be assigned for clinical practice and teaching.
19. You may be especially interested in working with specific faculty members. You may indicate this if you choose.
20. If your pre-pharmacy work was taken at an institution other than that from which you obtained your B.S. or Pharm.D. degree, please provide GPA's for both. Transcripts are required for Pharm.D. work.
21. Self-explanatory.
22. List only if exact scores are known, and have a copy of your record sent to the address given below. M.S. COMBINED PROGRAM: The GRE scores are required for admission to graduate school.
23. Interviews are strongly urged but not mandatory for acceptance. Please indicate if you would be able to visit The University of Texas (at your own expense). We will arrange a mutually convenient date for your interviews.

PLEASE RETURN THIS APPLICATION NOT LATER THAN JANUARY 15 TO:

Postdoctoral Training Committee
ATTN: Dr. William McIntyre
College of Pharmacy
The University of Texas at Austin
1 University Station, A1900
Austin, Texas 78712-0120
(512) 232-3407

* Numbers refer to information item numbers on the application form.

APPLICATION

The University of Texas and Affiliated Health Care Institutions

Check box that is applicable:

- Pharmacy Practice Residency Specialty Practice Residency
 M.S. in conjunction with a Specialty Practice Residency Fellowship in Clinical Pharmacy Science
 Ph.D. Program

NO PERSON SHALL BE EXCLUDED FROM PARTICIPATION IN, DENIED THE BENEFITS OF, OR BE SUBJECT TO DISCRIMINATION UNDER ANY PROGRAM OR ACTIVITY SPONSORED OR CONDUCTED BY THE UNIVERSITY OF TEXAS SYSTEM OR ANY OF ITS COMPONENT INSTITUTIONS, ON ANY BASIS PROHIBITED BY APPLICABLE LAW, INCLUDING, BUT NOT LIMITED TO, RACE, COLOR, NATIONAL ORIGIN, RELIGION, SEX OR DISABILITY.

1. I wish to apply for a Residency/Fellowship/ M.S. / Ph.D. Program commencing on _____, 20_____.

2. Name (Give full legal name, without abbreviations, as it appears on such official documents as birth certificate, license applications, etc.)

_____ (last name)

_____ (first name)

_____ (middle name)

3. UT EID (if you have one): _____

4. Male Female

5. Other names under which transcript may be filed, if more than one. Attach sheet and indicate institution where name is used.

6. Permanent Address

7. Mailing Address (if different from #6)

_____ (number)

_____ (street)

_____ (number)

_____ (street)

_____ (city)

_____ (state)

_____ (ZIP)

_____ (city)

_____ (state)

_____ (ZIP)

8. Country of Birth _____

9. Home Phone (_____) _____ - _____

10. Email Address _____

11. Fax (if applicable) (_____) _____ - _____

12. Date of Birth _____

(month)

(day)

(year)

13. U.S. Citizen? Yes No - State of Birth _____

14. Ethnic Background

Please indicate which of the following groups best describes your ethnic background. This information is voluntary and will be used in a nondiscriminatory manner, consistent with applicable civil rights laws. The information will be used for federal and/or state law reporting purposes only and will not be used in any acceptance decisions.

American Indian or Alaskan Native

African American, Black

Asian or Pacific Islander

Hispanic or Latino

White, Non-Hispanic

15. List undergraduate and graduate programs you have attended (include any you plan to attend before you enter the Residency/Fellowship/M.S./Ph.D.). Under "Degree", list chronologically (most recent degree, first) any you have received or will earn prior to July 1. Be sure to include the date the degree was or will be awarded.

Name of School or Institution & Address

Months & Years of Attendance

Major

Degree

Date

to

to

to

to

to

16. **RESIDENCY AND M.S. APPLICANTS ONLY** - I wish to develop my clinical expertise in:

- | | |
|--|---|
| <input type="checkbox"/> Pharmacy Practice (Community / Ambulatory Care) | <input type="checkbox"/> Medicine |
| <input type="checkbox"/> Pharmacy Practice (Managed Care) | <input type="checkbox"/> Oncology |
| <input type="checkbox"/> Pharmacy Practice (Institutional) | <input type="checkbox"/> Pharmacotherapy |
| <input type="checkbox"/> Drug Information | <input type="checkbox"/> Primary Care / Ambulatory Care |
| <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Solid Organ Transplant |
| <input type="checkbox"/> Other: _____ | |

17. **FELLOWSHIP, M.S., and PH.D. APPLICANTS ONLY** - Please describe investigational work you would like to pursue during your training.

18. **FELLOWSHIP APPLICANTS ONLY** – I wish to continue the development of my clinical expertise in:

- | | |
|---|--|
| <input type="checkbox"/> Drug Information | <input type="checkbox"/> Pharmacotherapy |
| <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Primary Care |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Medicine | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Oncology | |

19. The Texas clinician-preceptor(s) or faculty with whom I would prefer to work is (are):

I have no preferences, or will consider any UT affiliated preceptors.

20. My GPA in baccalaureate work was _____ (Pre-Pharm) _____ (Pharm) _____

21. My GPA in Pharm.D. work was _____

22. I have taken the Graduate Records Exam (GRE). The exact scores are: Verbal: _____ Quant: _____ Analyt: _____
Graduate School (M.S. / Ph.D.) Applicants Only

23. I would would not be able to interview onsite at The University of Texas.

I certify that all information given on this application is complete and correct.

I grant permission to share this information with all applicable residency directors with UTA and its affiliated programs.

(Signature of Applicant)

(Date)

RETURN COMPLETED AND ALL MATERIALS FORM TO:

POSTDOCTORAL TRAINING COMMITTEE
ATTN: DR. WILLIAM MCINTYRE
COLLEGE OF PHARMACY
THE UNIVERSITY OF TEXAS AT AUSTIN
1 UNIVERSITY STATION, A1900
AUSTIN, TEXASS 78712-0120

**please attach a recent
photograph
(color or black & white)**

(No application fee is required.)