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. 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.
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

(number) (street) (number) (street)
(city) (state) (ZIP) (city) (state) (ZIP)

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 ____________________________

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

(month) (day) (year)

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.

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

- Pharmacy Practice (Community / Ambulatory Care)
- Pharmacy Practice (Managed Care)
- Pharmacy Practice (Institutional)
- Drug Information
- Geriatrics
- Infectious Disease
- 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:

- Drug Information
- Geriatrics
- Infectious Disease
- Medicine
- Oncology
- Pharmacotherapy
- Primary Care
- Psychiatry
- Other:

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: _______

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.)