CHICAGO STATE UNIVERSITY

College of Pharmacy
Preceptor Application for Faculty Appointment

Name *(First, MI, Last)*			**Pharmacist License #**	**License in Good Standing?** ☐Yes ☐No ☐N/A
Home Address			**City** / **State** / **Zip**	
Primary e-mail address	**Date of Birth**	**Gender(M/F)**	**Home Phone**	**Cell Phone (optional)**

Race/Ethnicity (check one only): Response is optional; not used to determine eligibility and decision for appointment.
☐Hispanics of any race
For Non-Hispanic/Latino Individuals only:
☐Asian or Pacific Islander ☐Black
☐American Indian or Alaskan Native ☐White
☐I choose not to respond ☐Other

Citizenship (check one only):
☐US Citizen
☐Non US Citizen(**List VISA #**):
☐Permanent Resident(**List Perm Res #**):
☐Political Asylum
☐Unknown

Name of Practice Site (include store number if applicable)	**Title/Position**	**Business Phone**
Pharmacy/Site License #	**License in Good Standing?** ☐Yes ☐No ☐N/A	
Business Address	**City** / **State** / **Zip**	

Practice Type (Check All That Apply):
☐Community-Independent ☐Community-Retail or Chain ☐Ambulatory Care ☐Hospital/Health System
☐Home Infusion ☐Long-Term Care ☐Public Health ☐Other(specify):

Degree(s)obtained:
☐BS ☐PharmD ☐MS ☐PhD
☐Other:

Certifications:
☐BCPS ☐BCPP ☐CDM ☐CGP ☐CACP
☐BBCNSP ☐BCNP ☐BCOP ☐BC-ADM ☐Other (List):
Residency/Fellowships:
☐PGY1 ☐PGY2 ☐Other(List):

Professional Honors:
☐FACCP ☐FASHP ☐FAPhA ☐FASCP
Other (List):

Are you a preceptor for other schools/colleges of pharmacy?
☐No ☐Yes (List schools/colleges):
Date of last rotation:
If "No", have you ever been a pharmacy student preceptor?
☐No ☐Yes
Are you currently a PGY1 or PGY2 pharmacy resident? ☐No ☐Yes

Do have a current faculty appointment with a school/college (of pharmacy)? ☐No ☐Yes
If yes, what type of appointment do you have?
☐Adjunct Clinical Instructor ☐Clinical Professor ☐Asst/Associate Professor
☐Adjunct Clinical Asst./Associate Professor ☐Clinical Asst./Associate Professor ☐Other

Please indicate if you are requesting an adjunct instructor appointment with CSU-COP? ☐No ☐Yes

Total Years of Practice Experience ☐<1 ☐1-3 ☐4-6 ☐7-10 ☐10-20 ☐>20	**Total Years as a Preceptor:** ☐<1 ☐1-3 ☐4-6 ☐7-10 ☐10-20 ☐>20	**Total Years at Current Practice Site**:

Indicate classification of Practice Site/Rotation type:
☐Community ☐Public Health ☐Chronic Care ☐Ambulatory Care ☐Medical Specialty
☐Institutional ☐General Medicine ☐Acute Care ☐Elective

I attest that the above information is complete and accurate to the best of my knowledge in order to participate as a preceptor for the professional practice program. I also agree to adhere to all guidelines of the program including completing the preceptor orientation requirements.
Signature:_____(☐**Check This Box As Signature if Electronically Submitting**) **Date**:

Please mail, fax, or email this form and a copy of your current CV and IDFPR or applicable state pharmacist license to:
Chicago State University College of Pharmacy, Douglas Hall 206, 9501 S King Drive, Chicago, IL 60628
Attn: Office of Experiential and Continuing Professional Education, 773-821-2217 (fax), tthoma37@csu.edu

For Office Use Only: In Good Standing: Y___ N___ 1 Year of Pharmacy Practice Experience: Y___ N___ 6 Months of Experience at Current Site: Y___ N___
Meets minimum requirements to be a Preceptor: Y_____ N_____ OECPE Initials_____ Date: _____20_____
OECPE initial site visit completed: Y_____ N_____
OECPE Site Visit Exempt: IPPE Director_____, APPE Director_____, Asst. Dean_____
Banner ID#_____ OECPE Initials_____ Date Entered _____20_____