APPLICATION FOR CERTIFICATE OF EXCELLENCE in MEDICATION-USE SAFETY AND PHARMACY PRACTICE

USE THIS APPLICATION FOR ORGANIZATIONS WITH RESIDENCY PROGRAMS THAT ARE INVOLVED IN THE ASHP ACCREDITATION PROCESS.

This form must be completed and submitted to ASHP's Practice Advancement Office by email to COE@ashp.org at the time of application for certification or recertification as a Center of Excellence.

Name of Organization:

Address:

Address:

City/State/Zip:

Telephone:

TERMS AND INFORMATIONAL REQUIREMENTS

1. The above organization is applying for ASHP certificate of excellence in medication-use safety and pharmacy practice. This application form must be completed in full; signed by the chief pharmacy officer/pharmacy executive and the organization's chief executive officer and then accepted by the ASHP Practice Advancement Office before any further actions will occur on the application.

2. The organization named above accepts and understands the sole basis for certification are the requirements in the currently effective *ASHP Regulations On Certificate Of Excellence in Medication-Use Safety And Pharmacy Practice* (Regulations), and the currently effective *ASHP Standard for Certificate Of Excellence in Medication-Use Safety And Pharmacy Practice (Standard*). The current documents are available on the ASHP website, www.ashp.org. These Regulations and Standards are incorporated by reference into this application form.

3. To the best of the applicant's knowledge, the pharmacy service of this organization for which certification is being sought meets the requirements of the certificate Regulations and Standards by which the pharmacy services will be reviewed.

4. The organization agrees and accepts that any and all decisions to award certification to the pharmacy services of the organization are contingent upon the pharmacy services being compliant with the relevant certification Regulations and Standard, as determined by the official ASHP survey and review process.

5. All decisions to certify pharmacy services are determined solely through the ASHP Pharmacy Practice Accreditation Commission as authorized by the ASHP Board of Directors.

6. This organization conducts ASHP-accredited, preliminarily-accredited, candidate, or pre-candidate status residency programs. ☐ Yes ☐ No
   If yes, please list these programs and the most recent year accredited: _____
   _____
   _____
   _____
   _____

7. The pharmacy services are conducted at: ☐ one site ☐ multiple locations
   If multiple locations, the pharmacy requests certification at ____ (number of) locations. Please provide the name(s) and location addresses:_____
   _____
   _____
   The pharmacy services at each location for certification are under centralized policies and procedures:
   ☐ Yes ☐ No
   The pharmacy services at each location for certification are under centralized pharmacy management
   ☐ Yes ☐ No

8. Please indicate the distance between each location and the primary site:_____
   _____
   _____

Having read and understood the above application form, the Terms and Required Information, and the Regulations and applicable Standard for certification, the Organization agrees to the requirements outlined, and certifies that the responses provided in the application are correct and accurate.

Pharmacy Executive's Information:

Name:
Title:
Phone:
Fax:
E-Mail

Signature, Pharmacy Executive

Chief Executive Officer's Information:

Name:
Title:
Phone:
Fax:

Signature, Chief Executive Officer
(If CEO address is different from the Organization's please supply.)

DATE _____

ASHP Use Only
Program Code:
ID Number:

Date Received: