

# APPLICATION FOR ACCREDITATION

**OF INTERNATIONAL HOSPITAL AND HEALTH-SYSTEM PHARMACY SERVICES**

**This form must be completed and submitted to ASHP's Practice Advancement Office (email:** **global@ashp.org****)**

 **at the time of application for accreditation of an international hospital and health-system pharmacy service.**

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| Name of Organization: |
| Address: |
| City/State/Zip: |
| Country: |
| Telephone: |

**TERMS AND INFORMATIONAL REQUIREMENTS**

1. The above organization is applying for ASHP accreditation of an international hospital and health-system pharmacy service. This application form must be completed in full; signed by the director of pharmacy and the CEO; and 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 accreditation are the requirements in the currently effective *ASHP Administrative Procedures on Accreditation of International Hospital and Health-System Pharmacy Services* (Administrative Procedures), and the currently effective *ASHP Accreditation Standard for International Hospital and Health-System Pharmacy Services (Standard*). The current documents are available on the ASHP website, [www.ashp.org.](http://www.ashp.org/) These Administrative Procedures and Standard are incorporated by reference into this application form.
3. To the best of our knowledge, the pharmacy service of this organization for which accreditation is being sought meets the requirements of the accreditation Administrative Procedures and Standard by which the pharmacy services will be reviewed.
4. The organization agrees and accepts that any and all decisions to award accreditation to the pharmacy services of the organization are contingent upon the pharmacy services being in compliance with the relevant accreditation Regulations and Standard, as determined by the official ASHP survey and review process.
5. All decisions to accredit pharmacy services are determined solely through the ASHP International Accreditation Commission as authorized by the ASHP Board of Directors.
6. The pharmacy services are conducted at: one site or multiple locations

 If multiple locations, the pharmacy requests accreditation at \_\_\_\_number of locations. Please provide the name(s) and location addresses: \_\_\_\_\_\_\_\_\_\_\_

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1. Please indicate the distance between each location and the primary site: \_

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

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| **Director of Pharmacy’s Information:** |
| Name: |
| Title:  |
| Phone:  |
| Fax:  |
| E-Mail: |
|  |
| Signature, Director of Pharmacy |

 |  | **Chief Executive Officer’s Information:** |
| Name: |  | Name:  |
| Title: |  | Title: |
| Phone: |  | Phone:  |
| Fax: |  | Fax:  |
| E-Mail |  |  Signature, Chief Executive Officer**(If CEO address is different from the Organization’s please supply.)** |
|  Signature, Director of Pharmacy |  |
|  |  **DATE :SUBMITTED:**  |  |
|  |  |  |
|  |  | **ASHP Use Only:** |
|  |  | **Program Code:** |
|  |  | **ID Number:** |
|  |  |  |
|  |  | **Date Received:** |
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