University of Virginia Health System
PGY-1 Pharmacy Residency
Application Form

Name: _____
Last First Middle

Present Address:

_____
(Street)

_____
(City, State, Zip Code)

_____
(Phone)

Permanent Address:

_____
(Street)

_____
(City, State, Zip Code)

_____
(Phone)

College of Pharmacy:

_____

_____

_____

Expected Graduation Date: _____

References: Please list the names, titles, and addresses of the individuals whom you have requested to send letters of reference.

1. _____
   _____
2. _____
   _____
3. _____
   _____

Explain why you wish to enter a residency program:

Briefly describe your future goals in pharmacy:

Have you applied to the ASHP Resident Matching Program? Yes _____ No _____
Residency Match Number: _____

_____ _____
Date of completion Signature of applicant

Send completed application materials by January 2, 2008 to:

Michelle McCarthy, Pharm.D.
Director, PGY1- Pharmacy and PGY2-Drug Information Residency Programs
Department of Pharmacy
University of Virginia Health System
P.O. Box 800674
Charlottesville, Virginia 22908-0674

* **Application materials required include: Completion of application form, a letter of intent, 3 letters of recommendation, Official Copy of Pharmacy College/University transcripts, and an up to date Curriculum Vitae.**