

PGY1 PHARMACY RESIDENCY APPLICATION

Name: _____ Social Security #: _____
(Last, First, Middle Initial)

CONTACT INFORMATION:

Current Address: _____

_____ City State Zip Code

Telephone: _____ Date effective to: _____

Email: _____

Permanent Address: _____

_____ City State Zip Code

Telephone: _____ E-mail: _____

APPLICATION CHECKLIST

All applications have to include the following, and are due January 5, 2010. Electronic copies are acceptable.

- Application form
- Letter of intent
- Curriculum vitae
- College transcript
- Letters of recommendation (3)

I am a licensed pharmacist in the state of New York or
am eligible for licensure in the state of New York
(U.S. citizen or hold permanent resident status in the U.S.) Yes No

Will you be able to start the program on July 1, 2010? Yes No

I certify that all information in the application materials is complete and accurate to the best of my knowledge.

Signature _____ Date _____

Please send all completed applications to:

Adrienne Hewryk, Pharm.D.
Residency Program Director
New York Presbyterian Hospital
Department of Pharmacy
525 East 68th Street, Rm. K-04
New York, NY 10065-4897
Phone: (212)746-0744
Fax: (212)746-8506
Email: adh9010@nyp.org

(To ensure your materials are received by the deadline, please email your application, letter of intent and CV. Letters of recommendation can also be emailed. Hard copies of all materials must ultimately be mailed and received for a complete application.)