



## UT COLLEGE OF PHARMACY / UTMC PHARMACY PRACTICE (PGY1) RESIDENCY APPLICATION AND INSTRUCTIONS

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### INSTRUCTIONS

#### **GENERAL INSTRUCTIONS:**

Please complete all requested portions of the application.

#### **RESIDENCY MATCHING PROGRAM:**

Residents and Institution have participated in and adhered to the rules of the Resident Matching Program process.

#### **CURRICULUM VITAE:**

Enclose a copy of your current curriculum vitae. Your curriculum vitae should include the colleges and/or universities attended (including dates), degrees conferred or expected, professional experiences, rotation/clerkship experiences, extracurricular leadership experiences, and other academic and professional achievements.

#### **LETTER OF INTEREST:**

A letter of interest should include short-term and long-term professional goals, motivation for residency training, and why you are interested in the University of Toledo Residency Program.

#### **TRANSCRIPTS:**

Submit official pharmacy school transcript(s) for all post-secondary coursework and graduated from an ACPE accredited School or College of Pharmacy with a Doctorate of Pharmacy degree.

#### **LETTERS OF RECOMMENDATION:**

Three letters of recommendation are required. Please provide each individual completing the recommendation a Residency Applicant Recommendation Request Form. Letters of recommendation should be sent directly to the University of Toledo Medical Center. All letters of recommendation must be **received** by **February 1<sup>st</sup>**.

#### **DEADLINE:**

All application materials must be **received by February 1<sup>st</sup>**.

#### **INTERVIEW:**

An on-site interview at the University of Toledo Medical Center is required.

#### **LICENSURE:**

Residents must be eligible for licensure as a registered pharmacist in the state of Ohio, and are expected to complete the licensure process or apply for reciprocity by the end of July.

# PHARMACY PRACTICE (PGY1) RESIDENCY APPLICATION

\_\_\_\_\_  
Name

\_\_\_\_\_  
@  
E-mail Address

[ ]\* **PERMANENT ADDRESS:**

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
( ) -  
Telephone

[ ]\* **PRESENT ADDRESS:**

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
( ) - ( ) -  
Telephone (home) (work)

\*Preferred mailing address

## **SUBMITTING THE APPLICATION:**

Address all materials to:  
**Attn: Chad Tuckerman, Pharm.D.**  
**Residency Program Director**  
**University of Toledo Medical Center**  
**Department of Pharmacy Services**  
**3000 Arlington Avenue**  
**Toledo, OH 43614**  
**419-383-6849**

**[Chad.Tuckerman@utoledo.edu](mailto:Chad.Tuckerman@utoledo.edu)**

**RECOMMENDATIONS:**

Please provide the name, address, phone number, fax number, and e-mail address for each individual completing a recommendation.

1.

2.

3.

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Applicant Signature

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Date



**UT COLLEGE OF PHARMACY / UTMC  
PHARMACY PRACTICE (PGY1) RESIDENCY  
APPLICATION**

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**REQUEST FOR RECOMMENDATION**

**To be completed by the applicant**

Name of Applicant:  
(Please print or type)

First Name	MI	Last Name
Street Address or P.O. Box		
City	State	Zip
( ) -		
Telephone		

I waive the right to review this recommendation.

\_\_\_\_\_  
Signature of Residency Applicant

**To be completed by individual completing the recommendation**

Applicants to our residency program are required to have letters of recommendation submitted by persons who are in a position to evaluate their qualifications for residency training. The individual completing the recommendation is asked to make an honest appraisal of the applicant's character, personality, abilities, and suitability for a pharmacy residency. All comments and information provided will be kept in strict confidence as allowed by Ohio Law. In your letter of recommendation, please address each of the following:

- How long you have known the applicant and in what capacity?
- What are the applicant's strengths and weaknesses?
- How would you rate the applicant's time management skills?
- How is the applicant able to deal with difficult personalities and situations?
- How is the applicant motivated to perform at a high level in stressful situations?
- What is your recommendation on the applicant's candidacy?

\_\_\_\_\_  
Signature of individual completing the recommendation

\_\_\_\_\_  
Typed or printed name and title

\_\_\_\_\_  
Institution/Company

\_\_\_\_\_  
Address or P.O. Box

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
( ) - ( ) -  
Telephone Fax

The letter of recommendation should be mailed or faxed to:

Chad Tuckerman, Pharm.D.  
University of Toledo Medical Center  
Department of Pharmacy Services  
3000 Arlington Avenue  
Toledo, OH 43614  
Fax (419) 383-3032



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APPLICATION**

**REQUEST FOR RECOMMENDATION**

**To be completed by the applicant**

Name of Applicant:  
(Please print or type)

First Name	MI	Last Name
Street Address or P.O. Box		
City	State	Zip
( ) -		
Telephone		

I waive the right to review this recommendation.

\_\_\_\_\_  
Signature of Residency Applicant

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\_\_\_\_\_  
Signature of individual completing the recommendation

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Typed or printed name and title

\_\_\_\_\_  
Institution/Company

\_\_\_\_\_  
Address or P.O. Box

\_\_\_\_\_  
City                      State      Zip

( ) -                      ( ) -  
Telephone                      Fax

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APPLICATION**

**REQUEST FOR RECOMMENDATION**

**To be completed by the applicant**

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(Please print or type)

First Name	MI	Last Name
Street Address or P.O. Box		
-		
City	State	Zip
( ) -		
Telephone		

I waive the right to review this recommendation.

\_\_\_\_\_  
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Signature of individual completing the recommendation

\_\_\_\_\_  
Typed or printed name and title

\_\_\_\_\_  
Institution/Company

\_\_\_\_\_  
Address or P.O. Box

City	State	Zip
( ) -	( ) -	
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