



# Children's Hospital of The King's Daughters

## Application for Pediatric Pharmacy Practice Residency Program

**DEADLINE**

January 15

**PROCEDURE**

Complete this application form and return it with a copy of your curriculum vitae and letter of intent by the application deadline. Please include all pharmacy clerkship experience on your curriculum vitae. The letter of intent should discuss your professional career goals and your reasons for pursuing the residency at Children's Hospital of The King's Daughters.

Request an original copy of your Pharm.D. program transcript to be mailed to the address listed below.

Request three letters of recommendation to be mailed to the address listed below. Preferably, two letters should be from clinical clerkship preceptors. The third letter may be from either another faculty member or from a supervisor at your place of employment.

Please attach passport size picture to application.

**APPLICATION INFORMATION** Please print or type the following information:

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_ E-mail: \_\_\_\_\_

**EDUCATION**

- B.S. Year \_\_\_\_\_ School \_\_\_\_\_
- Pharm.D. Year \_\_\_\_\_ School \_\_\_\_\_
- Post-graduate training Year \_\_\_\_\_ School \_\_\_\_\_
- Other Year \_\_\_\_\_ School \_\_\_\_\_

**PROFESSIONAL REFERENCES**

Name \_\_\_\_\_ Title \_\_\_\_\_

Telephone \_\_\_\_\_ E-mail \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Telephone \_\_\_\_\_ E-mail \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Telephone \_\_\_\_\_ E-mail \_\_\_\_\_

**Send completed residency application to:**

Children's Hospital of The King's Daughters  
Department of Pharmacy  
Attention: Michael Chicella, Pharm.D.  
601 Children's Lane  
Norfolk, Virginia 23507  
Phone: (757) 668-7684  
Fax: (757) 668-7482