

## Application Instructions Working Professional Doctor of Pharmacy Degree Program

### **\*\*ATTENTION APPLICANTS\*\***

**The admission application process has been revised as of February 2010.**

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#### **I. WPPD PROGRAM ELIGIBILITY**

**Applicants to the WPPD program must be licensed pharmacists that are currently working within the field of pharmacy. In addition, all applicants need access to patients as well as the ability to easily obtain patient medical records, including lab data, test and procedure results, medication profile, and medical history.**

##### **US Applicants:**

- Current US Pharmacy Licensure
- Bachelor degree in Pharmacy from a US or Canadian College of Pharmacy with a minimum 2.0 Grade Point Average
- Access to Patients and Patient Records (lab data, medical history, medication profiles) at an approved hospital or medical center

##### **US Applicants that are Graduates of Puerto Rico or International Pharmacy Programs:**

- Current US Pharmacy Licensure
- Bachelor degree in Pharmacy equivalent to US College of Pharmacy degree with a minimum 2.0 Grade Point Average
- TOEFL iBT scores taken within the last 2 years – a minimum composite score of 100 is preferred (Minimum Required Score for Each Scale: Reading 20, Listening 20, Speaking 25, Writing 23)
- Access to Patients and Patient Records (lab data, medical history, medication profiles) at an approved hospital or medical center

##### **Canadian Applicants:**

- Current Canadian Pharmacy Licensure
- Bachelor degree in Pharmacy from a US or Canadian College of Pharmacy with a minimum 2.0 Grade Point Average (*Graduates of Non-US or Canadian College of Pharmacy are not eligible for the WPPD Program*)
- Access to Patients and Patient Records (lab data, medical history, medication profiles) at an approved hospital or medical center

##### **International Applicants:**

**Applicants residing and/or practicing outside of the US or Canada are not eligible for the WPPD Program.**

## II. APPLICATION SUBMISSION

**1) UF Online Application** - The University of Florida application must be submitted online, in addition to the \$30 application fee, which can be submitted online by credit card or mailed in by check (made payable to the University of Florida) to the Admissions Office (the UF Admissions Office address is listed on the form that you print out and send in with the check).

The online application can be accessed at <http://www.admissions.ufl.edu/>. (Step-by-step instructions are available on the WPPD website at [www.cop.ufl.edu/wppd](http://www.cop.ufl.edu/wppd))

**After completing the University of Florida online application, print out the Application Summary and mail it to the WPPD Support Center with the written application forms provided to you.**

**2) Written WPPD Application** – The Working Professional Doctor of Pharmacy program application must be completed and submitted in its entirety. Documents for submission include: a statement of professional goals and personal profile questions, transcripts, letters of recommendation, resume, current CPR/AED/BLS certification, employer letter of support, proof of current pharmacy licensure, and copy of diploma. *Graduates of Non-US and Canadian schools of pharmacy must also submit TOEFL iBT scores and a course-by-course transcript evaluation by Education Credential Evaluators, Inc.* Please keep copies of all materials submitted for your own records.

**Please do not send individual documents. All applications must be received in their entirety. An application checklist is included on the following page. The application deadline is strictly observed.**

### MAIL COMPLETED APPLICATION TO:

**University of Florida/WPPD  
WPPD Support Center  
2145 Metrocenter Boulevard, Suite 400  
Orlando, FL 32835**

**TEL: (800) 431-6687 FAX: (407) 395-0013**

## III. APPLICATION RECEIPT ACKNOWLEDGEMENT, ADMISSION STATUS

You will be mailed an acknowledgement of receipt when your completed WPPD application packet is received by mail. You should expect to receive written notification of your official status approximately 4-6 weeks following the application deadline. Your application will first be reviewed by a WPPD Sub-Committee and then forwarded to the Admissions Committee for a final decision.

## IV. FINANCIAL AID INFORMATION

Financial aid information may be obtained by calling Mike Menefee, Assistant Director of Student Financial Affairs, University of Florida, at (352) 273-6202. Financial aid for this program must be used on a reimbursement basis. All tuition must be paid by the registration deadline and can not be deferred while awaiting financial aid.

## WPPD Application Checklist:

Each item should be completed and mailed in its entirety to the WPPD Support Center. Please print and keep a copy of all documents submitted for your own records. The application deadline is strictly observed.

- Printout of the Online Application Summary
- Statement of Educational Goals & Personal Profile Questions - Responses must be **TYPED on a separate sheet of paper. Do not handwrite your answers on the questionnaire.**
- Employer's Letter of Support Form - Completed and signed. (If employer support can not be obtained or if you prefer not to inform employer of your educational endeavors, please include typed explanation on separate sheet of paper.)
- Access to Patients Form - Completed and signed.
- 2 Letters of Recommendation Forms - All references should be current, professional, and specific to your application to this program. Please have the evaluator place their responses in a separate, sealed envelope and write their signature over the back seal.
- Resume or Curriculum Vitae - Submit current copy.
- Current Pharmacy Licensure - Submit evidence of current pharmacy licensure. **If you are licensed in multiple states, please submit copies of all.**
- Graduation Certificate - Submit photocopy of diploma. **If you do not have a copy or are unable to submit a photocopy, please include a typed explanation.**
- Official Transcripts - Submit official copies from **ALL** undergraduate and graduate institutions attended. **Official transcripts must be in an envelope sealed by the institution.**
- CPR/AED/BLS for Health Care Providers Certification - Submit evidence of recent successful completion of a CPR/AED/BLS course designed specifically for health care providers. The American Red Cross CPR/AED for the Professional Rescuer/Health Care Provider certification course or the American Heart Association BLS for Healthcare Providers certification course is preferred. Proof that a course has been scheduled will be accepted until course completion takes place.
- Completed UFL Immunization Form
- Foreign pharmacy school graduates must provide a "Course-by-Course" evaluation of transcripts by Educational Credential Evaluators, Inc. Please contact them at 1-414-289-3400 or visit their website at [www.ece.org](http://www.ece.org). Foreign graduates must have a Bachelor degree equivalent to a BS in Pharmacy from a US college of pharmacy. \*Graduates of Puerto Rico pharmacy programs must provide evaluation only if transcript is not provided in English by institution.
- Foreign pharmacy school graduates (Puerto Rico included) must provide TOEFL iBT (Internet Based Test of English as a Foreign Language) scores. Scores are only valid if taken within 2 years. Please contact the Educational Testing Service at 1-609-771-7714 or visit their website at [www.ets.org/toefl/](http://www.ets.org/toefl/). See Eligibility Requirements for minimum score requirements.

# Working Professional Doctor of Pharmacy Program University of Florida - College of Pharmacy

Name: \_\_\_\_\_

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**On a separate sheet of paper, please TYPE answers to the following questions in a clear, concise manner. Be sure to include your name at the top of the page and staple your responses to this sheet. A response to each question in Sections I & II is REQUIRED.**

## **I. Statement of Educational Goals**

Please state your reasons and circumstances for pursuing the Doctor of Pharmacy Degree in 100-200 words.

## **II. Personal Profile**

Please respond to the following questions. Each answer should be no more than 100 words.

1. In addition to obtaining the Pharm.D. Degree, what other goals do you have in life? How do you plan to achieve them?
2. What do you value most in your life? Why?
3. What area of pharmacy practice interests you? Why?
4. How would you describe your personality?
5. What areas of your personal development do you think you need to improve upon?
6. What is the strongest aspect of your personality?
7. What pharmacy positions (work) have you held since graduation from a college of pharmacy?
8. What community service activities have you been a part of since graduation from a college of pharmacy?
9. What professional activities have you been involved in since graduation (pharmacy organizations, volunteering, etc.)?
10. Do you have any withdrawals, incompletes, or failing grades on your school transcripts? If so, please explain.
11. Have you ever been on probation or suspended from a college? If so, please explain.
12. What are your plans once you obtain the Doctor of Pharmacy degree?

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**Access to Patients Form**

Students in the WPPD program must have access to patients and their medical records (medication profiles, lab values, etc.) for basic coursework (case presentations) and program clinical requirements (CPAs). Students must be able to personally interview, "work-up", and present their patients in small group meetings. **Applicants must secure access to patients and their medical records prior to submitting this application.**

Please indicate below the name(s) of the provider and/or institution through which you have already secured access to patients and their medical records as well as the type of institution or provider below:

<b>Name of Institution or Provider and Type of Institution/Provider</b> (ex. pediatrics, long term care)	<b>Address/Location</b>	<b>Contact</b> (Person granting permission)	<b>Phone Number</b>

I hereby declare that I have obtained Access to Patients and give the College of Pharmacy permission to contact the provider(s) to verify this access.

**Applicant's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Applicant's Name (Please Print)**  
\_\_\_\_\_

**Applicant's UF ID Number** \_\_\_\_\_ - \_\_\_\_\_



**Working Professional Doctor of Pharmacy Program  
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**Employer's Letter of Support  
(PLEASE PRINT)**

**Applicant Name:** \_\_\_\_\_

If you are **NOT** self-employed, please have your employer complete the section "EMPLOYER SECTION." If you **ARE** self-employed, complete the section entitled "SELF-EMPLOYED."

**EMPLOYER SECTION - Please complete this section.**

I support this pharmacist's desire to pursue studies toward the Doctor of Pharmacy degree through the Working Professional Doctor of Pharmacy Program at the University of Florida.

Supervisor's Name: \_\_\_\_\_

Title: \_\_\_\_\_

Company Name: \_\_\_\_\_

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

City, State and Zip: \_\_\_\_\_

*Please include area code.*

Telephone number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Signature (required): \_\_\_\_\_

Date: \_\_\_\_\_

I **DO NOT** support this pharmacist's desire to pursue studies toward the Doctor of Pharmacy degree through the Working Professional Doctor of Pharmacy Program at the University of Florida.

Signature (required): \_\_\_\_\_

Date: \_\_\_\_\_

**SELF-EMPLOYMENT SECTION – Please complete this section.**

In completing this section I hereby attest that I am currently self-employed.

Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Working Professional Doctor of Pharmacy Program  
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**Letter of Recommendation Form**

**Applicant's Name:** \_\_\_\_\_

**TO APPLICANT:** Please have a person who knows you well, such as a colleague, employer, professor, etc., to complete this form. Provide them with an envelope in which they can return to you sealed. Members of your family should not be asked to complete this form.

Please check one of the following regarding confidentiality:

\_\_\_\_\_ I waive the right to review this letter of recommendation.

\_\_\_\_\_ I do not waive the right to review this letter of recommendation.

I hereby give the College of Pharmacy permission to contact the evaluator regarding further information to aid in the Committee's decision for acceptance into the College of Pharmacy.

**Applicant's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**TO EVALUATOR:** Please complete, sign, and place this form in a sealed envelope. To ensure confidentiality, please write your signature over the seal on the back of the envelope and return to applicant for submission with admission materials.

This evaluation will be used by the Admissions Committee for the purpose of aiding the Committee in a fair decision for enrollment status. You may be contacted for more information by letter or telephone.

**(PLEASE PRINT)**

Evaluator's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

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

City, State and Zip: \_\_\_\_\_

*Please include area code.*

Telephone number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Evaluator's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

How long have you known the applicant? \_\_\_\_\_ Years \_\_\_\_\_ Months

Do you have any concerns about this person's ability to deal with the demands and pressures of the practice of pharmacy? \_\_\_\_\_ Yes \_\_\_\_\_ No

*If your answer to the above is yes, please provide a short summary of details, as you understand them.*

PLEASE CHECK THE APPROPRIATE ANSWER BASED ON YOUR OPINION.

1. Does the applicant display characteristics of integrity? \_\_\_\_\_ Yes \_\_\_\_\_ No

2. Does the applicant demonstrate thoroughness in fulfilling obligations? \_\_\_\_\_ Yes \_\_\_\_\_ No

*If your answer to either of the above is no, please provide a short summary of details, as you understand them.*

TO YOUR KNOWLEDGE, HAS THE APPLICANT EVER BEEN:

1. Suspended, expelled, asked to resign or otherwise disciplined by any educational institution? \_\_\_\_\_ Yes \_\_\_\_\_ No

2. Arrested for any criminal charge? \_\_\_\_\_ Yes \_\_\_\_\_ No

3. Delinquent in any financial obligations? \_\_\_\_\_ Yes \_\_\_\_\_ No

*If the answer to any of the above is yes, please provide a short summary of details, as you understand them.*

TO YOUR KNOWLEDGE, IS THE APPLICANT:

1. Presently beset by emotional disturbances, mental or nervous disorders such that he/she would be unable to meet the academic demands of a pharmacy degree program and professional conduct standards as a practitioner? \_\_\_\_\_ Yes \_\_\_\_\_ No

2. Excessive in the use of alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No

3. Presently addicted to or psychologically dependent upon the use of prescription drugs such that he/she would be unable to meet the academic and professional demands of a pharmacy degree program? \_\_\_\_\_ Yes \_\_\_\_\_ No

4. Involved in the use of unlawful drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No

*If the answer to any of the above is yes, please provide a short summary of details, as you understand them.*

Please rate the applicant by circling the appropriate number in the areas listed below (on the scale 1=Low, 5=HIGH). The Admissions Committee would greatly appreciate comments on each category, regardless of the rating you select. Your feedback is of great value to the Admissions Committee. Lack of comments may necessitate a phone call to discuss the Letter of Recommendation. Also, provide additional comments on the back of this sheet. Thank you for your cooperation.

Characteristic	Low		Avg.		High
1. Self-confidence	1	2	3	4	5
COMMENTS:					
2. Maturity	1	2	3	4	5
COMMENTS:					
3. Communication Skills	1	2	3	4	5
COMMENTS:					
4. Drive/Determination	1	2	3	4	5
COMMENTS:					
5. Motivation for Pharmacy Practice	1	2	3	4	5
COMMENTS:					
6. Academic Aptitude for Pharmacy School	1	2	3	4	5
COMMENTS:					



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*Please include area code.*

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COMMENTS:					
3. Communication Skills	1	2	3	4	5
COMMENTS:					
4. Drive/Determination	1	2	3	4	5
COMMENTS:					
5. Motivation for Pharmacy Practice	1	2	3	4	5
COMMENTS:					
6. Academic Aptitude for Pharmacy School	1	2	3	4	5
COMMENTS:					

