



**Texas Tech University Health Sciences Center**  
**School of Pharmacy**  
**Residency Application**

---

**Instructions:**

Applications should include:

- 1) Completed application form
- 2) Letter of interest (describe your interest in the residency program and your professional goals and objectives)
- 3) Curriculum vitae
- 4) Official transcripts from all pharmacy education.
- 5) Three (3) letters of recommendation (*Letters may be faxed directly to (214) 372-5020 emailed or sent in hard copy mailed to the address below.*) Letters should be sent directly by the recommender.

The deadline for application is:

**All Residencies: January 6<sup>th</sup>**

Applications will be reviewed as they are received so early submission is encouraged. Applicants are required to complete an onsite interview before a position will be offered.

Email completed application form, letter of interest, and curriculum vitae to:

Wendi M. Monroe

Residency Coordinator

Office of Residency Programs

email: [wendi.monroe@ttuhsc.edu](mailto:wendi.monroe@ttuhsc.edu)

- Letters of recommendation need to be signed and can be emailed, or faxed directly to (214)372-5020, or mailed to the address below.

- Official transcripts for all pharmacy education should be mailed to:

Office of Residency Programs

4500 S. Lancaster Road

Building 7 -- R#119A

Dallas, TX 75216

For information or questions, please phone: (214) 372-5300 or e-mail: [wendi.monroe@ttuhsc.edu](mailto:wendi.monroe@ttuhsc.edu)



# Texas Tech University Health Sciences Center

## School of Pharmacy Residency Application – page 1

**Applicant:** \_\_\_\_\_  
Last, First MI

**SSN:** \_\_\_\_\_ **E-Mail Address:** \_\_\_\_\_

**Current Address (residence):** \_\_\_\_\_

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

**Permanent Address:** \_\_\_\_\_

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

Please **CHECK** which residency program you are applying for. If you are applying to a residency available at multiple locations/sites, please check **ALL sites** that you would like to be considered for.

### PHARMACY PRACTICE RESIDENCIES

- PGY 1 Pharmacy Practice**
  - Abilene, Hendrick Medical Center
  - Dallas, Presbyterian Hospital\*
  - Dallas, VA Medical Center (VAMC)\*
  - Lubbock, University Medical Center

- PGY 1 Community Practice**
  - Amarillo, Texas Tech Patient Care Center Pharmacy

\*affiliated positions

**NOTE:** If you are applying for more than one TYPE of residency, please elaborate on your interests below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### PGY 2 SPECIALTY RESIDENCIES

- Critical Care**, Dallas VAMC
- Geriatrics**, Dallas VAMC
- Infectious Disease**, Dallas VAMC
- Ambulatory Care**, Dallas & Ft. Worth VAMC
- Hematology/Oncology**, Dallas VAMC
- Pediatrics**, Amarillo, Northwest Texas Hospital
- Pharmacotherapy** (2 year program)
  - Abilene, Hendrick Medical Center
  - Amarillo, Northwest Texas Hospital
  - Lubbock, University Medical Center

# School of Pharmacy Residency Application – page 2

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

**Professional Education:**

List colleges and universities attended with dates of attendance and degrees earned. (Please begin with most recent degree)

College or University	Dates Attended	Degree/Major	Completed
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Have you completed a pharmacy practice residency?**  Yes  No

**If yes:** \_\_\_\_\_  
*Residency Program* *Program Director*

**Are you licensed to practice pharmacy in the United States?**  Yes  No

**If yes:** \_\_\_\_\_  
*State* *Year Licensed* *License Number*

**Are you a United States Citizen?**  Yes  No If No, country of citizenship \_\_\_\_\_

**\*Type of visa, if applicable:** \_\_\_\_\_ **Resident Alien ID number, if applicable:** \_\_\_\_\_  
*(Please include copy)* *(Include date issued and front/back copy)*

**\*please note: we do not accept candidates on H1-B visas**

**I certify that the information submitted in this application is complete and correct to the best of my knowledge and belief. I grant Texas Tech Health Sciences Center permission, if necessary, to request additional information from previous schools and employers concerning my academic record and professional ability. Special Note: Because of the nature of clinical faculty appointments, Texas Tech may be required to provide affiliated institutions with personnel information, including social security numbers.**

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