Collaborative Practice Application Form

Applicant Profile

PHARMACIST NAME:	REGISTRATION NUMBER:	
MAILING ADDRESS (HOME):		
CURRENT EMPLOYER:		
MAILING ADDRESS (WORK):		
PHONE NUMBER(S): HOME:	WORK:	CELLULAR:
E-MAIL ADDRESS:		

Your collaborative practice will be related to?

Practice type:

General medicine
Paediatric medicine
Geriatric medicine
Surgical services
Psychiatric services
Other (please specify):

AND / OR

Health related type:

Dermatological disorders
Nutritional disorders
Men's health
Women's health
Other (please specify):

What will be the location for your collaborative practice?

Hospital	Community	Continuing Care
Clinic	Primary Care Network	Other (please describe):

How long have you been in practice?

Less than 2 years	2 – 5 years	6 – 9 years	10 or more years

Education and Training

List each of the education and/or professional development strategies you have completed relevant to your ability to practice collaboratively and provide details as requested. (Use additional paper if required)

1. Formal pharmacy-related education (beyond Bachelor of Science in Pharmacy) (e.g., Masters or Doctor of Pharmacy, hospital pharmacy residency)

Name of course	Institution and Location	Date Started	Date Completed	Specialty (if applicable)

2. Other training rotation(s) or mentorship(s) (ongoing or completed) outside of formal education

DATES:	
NAME AND POSITION OF PRECEPTOR/MENTOR:	
CONTACT INFORMATION: PHONE:	E-MAIL ADDRESS:
MAILING ADDRESS:	

DATES:	
NAME AND POSITION OF PRECEPTOR/MENTOR:	
CONTACT INFORMATION: PHONE:	E-MAIL ADDRESS:
MAILING ADDRESS:	

DESCRIBE TRAINING ROTATION OR MENTORSHIP (in 1,000 words or less)

3. Continuing Professional Development (CPD) and additional training and/or certificates applicable to collaborative practice.

Please provide the Form M's documenting your learning activities for the past two years that directly relate to your knowledge and skills development which facilitate your ability to practice collaboratively.

4. Based on your information in the Education and Training section, describe how you have acquired sufficient knowledge, skills and abilities to enable you to practice collaboratively. (in 1,000 words or less)

Include the following points in your response:
• Clearly describe the knowledge, skills and abilities you have acquired from the identified education and training activities relevant to collaborative practice. (RELEVANCE)
• Clearly describe the impact or benefit to your practice as a result of what you have learned and applied related to collaborative practice. (BENEFIT)

Experience and Practice

A. Provide a general description of your current practice (in 1000 words or less**).** As part of your response, please make sure you answer the following questions:

1. Provide a brief description of your practice site and your role within the practice site
2. How do you access patient records and information?
3. What systems are in place for monitoring and documenting patients' care?
4. How do you ensure continuity of care?
5. How do you ensure confidentiality?
6. How have you designed your practice to maximize patient safety?
7. How do you record patient information in a way that facilitates sharing, ease of use, and retrieval of patient information by authorized individuals, e.g., other health care providers caring for the patient or another pharmacist who is covering for you?

B. Describe your approach to a new client regarding the collection of pertinent data, assessing the client, identifying deficiencies in care, formulating a care plan and follow-up. (in 1000 words or less**).**

Collaborative Working Relationships
You must provide a letter of Collaboration (see Request for Letter of Collaboration) from the regulated health professional with whom you will be collaborating. If you will be collaborating with a group, the head of the group may sign on behalf of the group as long as all members of the group are in agreement; otherwise, each individual must sign a letter.

Provide the contact information for each regulated health professional that is providing a letter of collaboration on your behalf.

NAME:	TITLE:
NAME OF THEIR ORGANIZATION:	
ADDRESS OF THEIR ORGANIZATION:	
ROLE OF THIS COLLABORATOR:	
DAYTIME PHONE NUMBER:	E-MAIL ADDRESS:
LENGTH OF TIME YOU HAVE WORKED WITH THIS PERSON:	

NAME:	TITLE:
NAME OF THEIR ORGANIZATION:	
ADDRESS OF THEIR ORGANIZATION:	
ROLE OF THIS COLLABORATOR:	
DAYTIME PHONE NUMBER:	E-MAIL ADDRESS:
LENGTH OF TIME YOU HAVE WORKED WITH THIS PERSON:	

(Copy if more are required)

Collaborative Working Relationships

In 1,000 words or less, please describe how you have developed and participate in a collaborative relationship. Describe how you meet each of the following four criteria for a collaborative relationship:

"A collaborative relationship means a relationship between two or more regulated health professionals that is developed to:
• facilitate communication,
• determine mutual goals of therapy that are acceptable to the patient,
• share relevant health information, and
• establish the expectations of each participant when working with a mutual patient."

CONTACT number

Please provide a contact phone number where you may be contacted if members have any questions about medication orders you may write. _____

Declaration

I declare that all of the information on this application and all information supplied in support of this application are true and accurate to the best of my knowledge.

_____ _____

SIGNATURE: DATE: