Participant Application

Due June 1, 2017

Physician Organization Information		
Name of PO:		
Address:		
City:	State:	ZIP Code:
Name of PO Contact:		
Title:		
Phone:	Email:	

Physician Organization Readiness		
Pharmacy Transformation Champion identified?	☐ Yes ☐ No	Name (if identified):
If no, what is the plan for identifying Pharmacy Transformation Champion?		

Practice Site 1 Information		
Name of practice:		
Address:		
Phone:	Email:	
Site Contact:		
Title:		
How many physicians at this site?	How many mid-level providers?	
Physicians willing to sign collaborative practice agreement?		☐ Yes ☐ No
Wi-Fi access for data collection at this site?		☐ Yes ☐ No
Appropriate clinical space at this site?		☐ Yes ☐ No
Electronic Medical Record System?		☐ Yes ☐ No

Practice Site 2 Information		
Name of practice:		
Address:		
Phone:	Email:	
Site Contact:		
Title:		
How many physicians at this site?	How many mid-level providers?	
Physicians willing to sign collaborative practice agreement?		☐ Yes ☐ No
Wi-Fi access for data collection at this site?		☐ Yes ☐ No
Appropriate clinical space at this site?		☐ Yes ☐ No
Electronic Medical Record System?		☐ Yes ☐ No
**If additional sites are participating, please provide necessary information.		

Disclaimer and Signature	
I have read the Eligibility and Expectations document and agree that our organization fully supports the integration of clinical pharmacists in our primary care practice settings.	
Signature of applicant:	Date: