

 **FELLOW OF OSHP RECOGNITION PROGRAM APPLICATION**

**INTRODUCTION**

Fellow of OSHP (FOSHP) is a **Pharmacist Recognition Program** designed to acknowledge members who have made significant and sustained contributions to the Society and the profession. It is intended to foster and reward excellence in health-system pharmacy practice and promote public awareness of pharmacists who have distinguished themselves in the profession.

To be eligible for consideration, an applicant must be a current member of OSHP and have sustained membership in OSHP for at least seven years, have a record of outstanding service to the profession including at least five years of active involvement in OSHP, and at least ten years of professional experience and achievements in hospital and health-system pharmacy from the time of licensure.

**INSTRUCTIONS**

Please complete the application in its entirety. The purpose of this application is to establish an objective basis whereby applicants can be evaluated based on the Fellow criteria. Each application is reviewed by members of the FOSHP Recognition Committee, which recommends to the Board of Directors whether an applicant should be awarded Fellow status.

The FOSHP Recognition Committee will base its recommendations solely on the information supplied in this application. Additional information such as samples of published work, etc. will not be considered. The applicant’s *Curriculum Vitae* (CV) is used as a reference document for selected sections of the application and to assist with the Committee’s overall assessment of the applicant’s qualifications for Fellow of OSHP. To aid the committee in its review and avoid misinterpretation of the applicant’s CV, it is *recommended* to highlight activities and accomplishments in the space provided on this application form.

It is important to review the FOSHP Policy, as it will be used by the Committee in completing its review. The criteria are provided so applicants will be fully aware of the guidelines used in selecting Fellows.

In addition to the FOSHP Recognition Program Application, a complete submission will include the following:

1. **Personal Statements**: A concise, but sufficiently detailed personal statement that addresses each of the following:
	1. Your active participation in OSHP and significant contributions to health-system pharmacy and why you believe that a level of excellence has been achieved. Suggested maximum length is 500 words.
	2. The quality of your educational efforts for practitioners and others, such as precepting students or residents, mentoring staff, educating and training technicians and/or educating the public. Suggested maximum length is 500 words.
2. **Curriculum Vitae**
3. **References:** Names and contact information for three (3) colleagues (i.e., practitioners, administrators or academicians) who can attest to your achievement of the Fellow criteria.

**All application materials listed above must be sent via e-mail no later than September 9, 2024. Send to: mail@oshp.org.**

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# FOSHP Recognition Program Application

To be completed by the candidate or nominator.

Please type and enter all information in the unshaded cells.

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| --- |
| Applicant Information |
| Last Name |  | First Name |  | M.I. |  | ASHP ID #(if applicable) |  |
| Phonetic Pronunciation |  |
| Degrees/Certifications/Designations | ***(Please note: this information will be utilized for all Announcements and Publications)*** |
| **RESIDENCE** |
| Street Address |  |
| City |  | State |  | Zip |  |
| Telephone |  | E-mail  |  |
| **BUSINESS** |
| Current Position |  | Employer |  |
| Street Address |  |
| City |  | State |  | Zip |  |
| Telephone |  | Fax  |  | E-mail  |  |
| **MISCELLANEOUS** |
| Indicate to which address correspondence regarding the FOSHP Recognition Program should be sent. | [ ] Residence [ ] Business |
| Indicate name and degrees/certifications/ designations as they should appear on plaque if FOSHP status is achieved (maximum of three). | *(For example: John D. Doe, M.B.A., Pharm.D., BCPS)* |

**I. Membership in Professional Organizations**

*Active member of OSHP for at least 7 years. Not currently an elected officer, employee, or Recognition committee member of OSHP.*

* *Please note: Years of membership must be completed before submitting application.*

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| --- | --- |
| **Name of Organization** | **Member Since (Year)** |
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**II.** **Activities in Professional Organizations**

*Demonstration of active participation and service to OSHP activities at the regional or state level, or nationally through ASHP, for at least five (5) years (does not have to be consecutive years).*

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| --- | --- | --- |
| **Year** | **Organization** | **Office/Position/Activity** |
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**III.** **Contributions to Excellence in Health-System Pharmacy**

*Demonstration of sustained professional/practice commitment or contributions to excellence in health-system pharmacy for at least (10) years following pharmacy licensure. Document activities and accomplishments that exceed routine job requirements and reflect an ongoing degree of commitment to practice excellence.*

 List in reverse chronological order

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| --- | --- | --- |
| **Dates** | **Institution-Position/Activity/Contribution** | **Significant Achievements** |
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**IV. Contributions to the Total Body of Pharmacy Knowledge / Education**

*Contribution to the total body of knowledge in hospital and health-system pharmacy through educating practitioners, students, administrators, and/or the public.*

* *Please note: Inservice presentations or an institution’s internal publications* **ALONE** *are NOT considered as meeting this criterion.*

**A. Presentations (CE) and Poster Presentations to professional groups, organizations, and outside Institutions**

|  |  |  |
| --- | --- | --- |
| **Year** | **Group/Organization** | **Title** |
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**B.** **Publications in the Professional Literature**

*List both peer reviewed and non-peer reviewed scientific or professional papers, textbooks or textbook chapters.*

**C. Other (e.g., Newspaper articles, reports, CE monographs, videotapes)**

**D. Educational activities (e.g., APPE/IPPE preceptorship, PGY1/PGY2 training, teaching at a school of pharmacy, preceptorship at student events)**

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| --- | --- | --- |
| **Dates** | **Institution/School** | **Brief Description of Teaching, Preceptorship, or Mentoring Activities** |
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**E. Presentations to the Lay Public and Community**

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| **Dates** | **Group/Organization** | **Topic/Title** |
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**V. Postgraduate Honors and Awards**

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| **Date** | **Honor or Award** |
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**VI. References**

Provide the names below of at least three (3) different colleagues (i.e., practitioners, administrators, or academicians) who may attest to your achievement of the Fellow criteria:

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| --- |
| **Colleague Recommendations** |
|  | NAME | TITLE, CONTACT INFORMATION |
| (1) |  |  |
| (2) |  |  |
| (3) |  |  |
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By signing below, I verify that the application materials are true and complete.

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| --- | --- | --- | --- |
| Applicant’s Signature |  | Date |  |