

**CURRICULUM VITAE FORM
PROFESSIONAL ASSOCIATE, SCHOOL OF PHARMACY
MEMORIAL UNIVERSITY**

Name: _____

Business Address: _____

Telephone: _____ Fax: _____

E-Mail Address: _____

EDUCATION:

Post-Secondary Education: (include year & school)

Postgraduate Training: (include year & program)

Additional Certification: (include year of certification)

PRACTICE:

Registration Status: (with provincial regulatory body)

Practicing: Full-time Part-time Relief

Practice History: (Please list your employment and experience for the last 5 years)

PROFESSIONAL ASSOCIATIONS:

(If involved in professional/association committees please indicate & describe)

COMMUNITY ACTIVITIES:

AWARDS/HONOURS:

OTHER: (Presentations, Publications, Research)
