CURRICULUM VITAE FORM
PROFESSIONAL ASSOCIATE, SCHOOL OF PHARMACY
MEMORIAL UNIVERSITY

Name: _____

Business Address: _____

_____

Telephone: _____ Fax: _____

E-Mail Address: _____

MUN Student # (if applicable): _____

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:
(List professional associations and, if involved in professional/association committees, please indicate & describe)

_____

_____

_____

_____

HISTORY OF PRECEPTING PHARMACY OR OTHER HEALTH PROFESSIONAL STUDENTS:

_____

_____

_____

COMMUNITY ACTIVITIES:

_____

_____

_____

_____

AWARDS/HONOURS:

_____

_____

_____

OTHER: (Presentations, Publications, Research)

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