

*Xavier University of Louisiana  
College of Pharmacy/Louisiana State University  
Health Sciences Center*



*PGY-1 Pharmacy Residency Program  
Application*



**Xavier University of Louisiana College of Pharmacy**  
**PGY-1 – Pharmacy Residency Program**

All applicants are required to submit an application form, a letter of interest (outlining your short- and long-term career goals and reasons for pursuing pharmacy residency training), official academic transcript(s), and curriculum vitae.

**To be submitted by January 15th**

***Please send to:***

**John I. Okogbaa, BS, BA, PharmD, BCPS**  
Director, PGY-1 XUCOP/LSUHSC Pharmacy Residency Program  
Xavier University of Louisiana  
College of Pharmacy  
1 Drexel Drive  
New Orleans, LA 70125

**Phone:** (504) 520-5346  
**FAX:** (504) 520-7971  
**E-mail:** jokogbaa@xula.edu

**Please (type or print)**

**Applicant's name in full:**

\_\_\_\_\_

<b>Last</b>	<b>First</b>	<b>Middle</b>
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**Social Security Number** \_\_\_\_\_

**Present Address**

\_\_\_\_\_

<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Telephone</b>
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**Permanent Address**

\_\_\_\_\_

<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Telephone</b>
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**Email Address** \_\_\_\_\_

<b>Internal Use Only</b> <b>Date Received:</b> _____
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### Education

Name of College	Mailing Address	Dates Attended	Degree/Date received, or expected

### Professional Organizations

Organization	Office held	Dates

### Extra-curricular Activities (service projects, etc.)

Description	Dates

### Honors, Awards, Distinctions

Award	Dates

### Licenses (pharmacy, internships) and states

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**Employment History**

Employer's Name Address and Telephone Number	Dates Employed	Type of Work	Preceptor's Name (if applicable)

Have you ever been convicted for any violations of the law that would preclude pharmacy licensure?

- Yes  
 No

If yes, please explain:

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**References**

Please provide the name and contact information for the three individuals providing professional recommendation.

Name	Position	Address	Telephone Number	Relationship

**Statement of intention for application (signature required)**

I hereby apply to the Xavier University of Louisiana College of Pharmacy/Louisiana State University Hospital Pharmacy Residency Program, and I certify that the above information is true to the best of my knowledge. If accepted, I agree to comply with and be governed by all rules and regulations as outlined by Xavier University of Louisiana College of Pharmacy, and the Louisiana Board of Pharmacy.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_