



Thank you for your interest in the American College of Clinical Pharmacy PBRN (ACCP PBRN). To register as an existing PBRN, please complete the following information.

Existing PBRN Registry

PBRN Name Acronym*

Address 1*

Address 2*

City*

State/Province*

Zip*

Main Phone*

Main Fax*

Website

Network Director*

Director E-mail*

Primary Contact Person at Existing Network*

Contact E-mail*

Role of Contact*

PBRN Registry

Geographic Coverage*

(e.g., local, regional, national, etc.)

Underserved or Special Population or Disease Focus*

No

If yes, describe

Hold down 'ctrl' to select more than one item.

Clinics in the following states*

Alabama
Alaska
American Samoa
Arizona
Arkansas
Armed Forces America
Armed Forces Europe

Year Network Founded*

-Please Select-

Type of Network*

(e.g., family medicine, clinical pharmacy, HIV, etc.)

Mission Statement*

Existing PBRN Registry

Health Conditions of Interest*

Approximate Number of Network Members*

Primary Professional Degree of Member Investigators*

Physician

If 'Other', specify

Number of Clinical Pharmacist Investigators*

Approximate Number of Practices or Clinics*

Submit Registration

Thank you.