

San Diego Pharmacist Resource and Research Network

Network

San Diego Pharmacist Research Network is a practice-based research network in San Diego, California. Members engage in research projects that seek to identify and solve problems commonly encountered in their practices. The UCSD Skaggs School of Pharmacy and Pharmaceutical Sciences provides methodological expertise needed to complete the projects.

Mission

The mission of the network is to provide pharmacists with information and practice tools to improve quality and safety of medication use through collaborative, practice-based research.

Resources

Resources available to members include best practices for medication therapy management generated from research projects, research training, and assistance with collaborative practice and quality improvements.

Research

Network members collaborate with academic researchers to address challenges in practice. The projects are designed to maximize the gathering of data and to avoid disruption of patient services. Research results are disseminated to participating pharmacists as rapidly as possible. Our goal is to generate new knowledge through research and translate research into practice.

Membership

Benefits of becoming a member include:

- Propose and participate in practice-based research
- Network and collaborate with other pharmacists and researchers
- Receive information updates from research projects about best practices of medication therapy management, collaborative practice, and quality improvement
- Opportunities for research training
- Increase quality and safety of medication use provided to patients

Contact Information:

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UNIVERSITY of CALIFORNIA, SAN DIEGO
SKAGGS SCHOOL of PHARMACY
and PHARMACEUTICAL SCIENCES

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San Diego Pharmacist Resource and Research Network

Member Registration

Today's Date: _____

Personal Information: _____

Name (First, Middle, Last): _____

Title: _____

Email: _____

Profession: _____ (e.g. Pharmacist, Researcher)

Specialty: _____ Year(s) in
Practice: _____

Business Information:

Name of Business: _____

Your Practice Setting: _____ (e.g. retail, home care,
inpatient, outpatient, clinic)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Fax Number: _____

Topics That Interest You: _____

Comments: _____

Please send the registration information to:

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