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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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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