



English or French Language Proficiency Educational Institution Attestation Form

❖ Instructions for the Applicant

Please follow these steps to have this form forwarded to the College of Pharmacists of Manitoba (CPhM):

- Complete section A (Applicant Section) of this form in its entirety. Do NOT complete any portion of Section B (Educational Institution Section), as this will invalidate the form.
- Submit this form (including this instructions page) to the educational institution where you successfully completed your professional pharmacy education. You are responsible for fulfilling any additional procedures and/or fees required by the institution for this service.

IMPORTANT: To meet the requirements for a waiver under section 6 of the [CPhM Language Proficiency Requirements Policy](#), all components of the program - including clinical placements and practicums - must have been instructed, evaluated, and occurred in English or French.

❖ Instructions for the Educational Institution

A former student of your institution has applied to the College of Pharmacists of Manitoba (CPhM) for registration and licensure or listing as a pharmacy professional (pharmacist or pharmacy technician) in Manitoba, Canada.

To grant them a waiver from [CPhM's Language Proficiency Requirements Policy](#), CPhM requires confirmation directly from your institution that your pharmacy professional program has met the requirements outlined below.

Once completed, please sign, date and email this form directly to the College of Pharmacists of Manitoba (CPhM) to: registration@cphm.ca, OR you can mail it directly in a sealed envelope to the following address:

College of Pharmacists of Manitoba
c/o Centre for Professional Regulatory Collaboration
210 Commerce Drive, Winnipeg, Manitoba R3P 2W1

IMPORTANT: CPhM will only accept this form if it is submitted directly by the educational institution. Forms sent via personal email accounts (e.g., yahoo.com, @hotmail.com) will not be accepted. The email must be sent from an official institutional email address (e.g., university@institutionname.com, university@institutionname.edu) to verify authenticity.

CPhM Language Proficiency - Educational Institution Attestation Form

Section A: Information about the Applicant (To be completed by applicant)	
First Name:	Last Name:
Middle Name:	Previous Name(s) (if applicable):
Date of Birth (YYYY/MM/DD):	E-mail Address:
Institution/School Name:	Title of the Program Studied:
Dates of Attendance (From YYYY/MM to YYYY/MM):	
I authorize the release of the requested information below directly to the College of Pharmacists of Manitoba (CPhM). Applicant's Signature: Date Signed:	

Section B: Information about the Educational Institution (If any information in this section is completed by the applicant, the form is considered invalid)	
Name of Student:	Date of Birth Recorded (YYYY/MM/DD):
Institution/School Name:	Title of the Program:
Program Completed by applicant: ☐ YES ☐ NO	Dates of Attendance (From YYYY/MM to YYYY/MM):
Date of Graduation (YYYY/MM):	Qualification Awarded:
By initialing below, you confirm the following: That you are proficient in the following language (please check one): ☐ English ☐ French That you are authorized to complete this form on behalf of the institution. That the information provided accurately reflects the official institution records regarding this applicant and is complete and correct.	

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Section B: Information about the Educational Institution (If any information in this section is completed by the applicant, the form is considered invalid)	
Additionally, by initialing below, you are attesting to the following:	
_____ Initials	That all components of the pharmacy professional education program were <i>instructed entirely</i> in the following language during the applicant's period of study (please check one): ☐ English ☐ French
_____ Initials	That all components of the pharmacy professional education program were <i>evaluated entirely</i> in the following language during the applicant's period of study (please check one): ☐ English ☐ French
_____ Initials	That <i>all clinical placements and practicums</i> of the pharmacy professional education program occurred in English or French (<i>please circle one</i>), including all communications and interactions with patients, their caregivers, healthcare professionals and other members of the healthcare team, during the applicant's period of study.
This form was completed by:	
Name of Official Completing Form:	Title of Official Completing Form:
E-mail address:	Name of Institution:
Institution Address:	Institution Website Address:
Official's Signature:	Please place official institution seal here:
Date:	
Please return this Completed, signed, and dated form directly to the College of Pharmacists of Manitoba (CPhM) via email to: registration@cphm.ca or mail it directly in a sealed envelope to the following address: College of Pharmacists of Manitoba c/o Centre for Professional Regulatory Collaboration 210 Commerce Drive, Winnipeg, Manitoba R3P 2W1	
Standard Duration of the Program:	