College of Pharmacists of Manitoba
200 Tache Ave, Winnipeg MB R2H 1A7
(204) 233-1411 | cphm.ca | info@cphm.ca

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
200 Tache Avenue
Winnipeg, Manitoba
Canada R2H 1A7

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.

Section A: Applicant to Complete this Section	
First Name:	**Last Name:**
Middle Name:	**Previous Name(s) (if applicable):**
Date of Birth (YYYY/MMM/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:**	

Section B: Educational Institution to Complete this Section (If any information in this section is completed by the applicant the form is considered invalid)	
Name of Student:	**Date of Birth Recorded (YYYY/MMM/DD):**
Institution/School Name:	**Title of the Program:**
Program Completed by applicant: **YES NO** ***(Please Circle one)***	**Dates of Attendance (From YYYY/MM to YYYY/MM):**
Date of Graduation (YYYY/MM):	**Qualification Awarded:**
Standard Duration of the Program:	

Section B: Educational Institution to Complete this Section

(If any information in this section is completed by the applicant the form is considered invalid)

By initialing below, you confirm the following:

_____ (Initials)	That you are proficient in the English or French language. *(please circle one)*
_____ (Initials)	That you are authorized to complete this form on behalf of the institution.
_____ (Initials)	That the information provided accurately reflects the official institution records regarding this applicant and is complete and correct.

Additionally, by initialing below, you are attesting to the following:

_____ (Initials)	That all components of the pharmacy professional education program were ***instructed entirely*** in English or French (*please circle one*) during the applicant's period of study.
_____ (Initials)	That all components of the pharmacy professional education program were ***evaluated entirely*** in English or French (*please circle one*) during the applicant's period of study.
_____ (Initials)	That ***all clinical placements and practicums*** of the pharmacy professional education program occurred in English or French (*please circle one*), 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: **Date:** **(please place official institution seal here)**

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:

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