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 Employer 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 (employer section), as this will invalidate the form.
- Submit this form (including this instructions page) to the employer where you gained pharmacy professional work experience in a majority English or French country in a similar role or scope of practice as your application to the College of Pharmacists of Manitoba.

IMPORTANT: To meet the requirements for a waiver under CPhM's Language Proficiency Requirements Policy, the program must have taken place in a majority English or French country where it is the primary official and common language.

Instructions for the Employer

A former employee of your organization/business 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 you as an employer, attesting to their English or French language proficiency.

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 employer. Forms sent via personal email accounts (e.g., yahoo.com, @hotmail.com) will not be accepted. The email must be sent from an official business or organization email address (e.g., employer@buisnessname.com, employer@organizationname.org) 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:**
Employer Name:	**Job title:**
Dates of employment (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: Employer To Complete This Section (If any information in this section is completed by the applicant the form is considered invalid)	
Employee's full name:	**Date of Birth Recorded (YYYY/MMM/DD):**
Business Name:	**Business Address:**
Employee's Job title:	**Dates of Employment (From YYYY/MM to YYYY/MM):**

Section B: 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 applicant's employer.
_____ (Initials)	That the information provided accurately reflects the official employer records regarding this applicant and is complete and correct.

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

_____ (Initials)	That the primary language of written and spoken business in the workplace was English or French. *(please circle one)*
_____ (Initials)	That the applicant effectively communicated and comprehended both orally and in writing in English or French. *(please circle one)*
_____ (Initials)	The applicant provided direct patient care and collaborated with other healthcare professionals in English or French. *(please circle one)*
_____ (Initials)	That the applicant's role as a pharmacy professional required regular communication with staff, patients, and other healthcare professionals in English or French. *(please circle one)*
_____ (Initials)	The pharmacy's official communications with the pharmacy regulatory body were in English or French. *(please circle one)*

This form was completed by:

Name of Employer or Representative Completing Form:	Title of Employer or Representative Completing Form:
Direct E-mail address:	Business/Organization Address:
Business/Organization Website Address:	

Employer's Signature:	Date:	(please place official employer seal here if applicable)

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
200 Tache Avenue
Winnipeg Manitoba
Canada R2H 1A7