College of Pharmacists of Manitoba

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APPENDIX A
MEDICAL DIRECTOR, PHYSICIAN OR REGISTERED NURSE (EXTENDED PRACTICE)/NURSE PRACTITIONER DECLARATIONS IN SUPPORT OF AN EXTENDED PRACTICE PHARMACIST APPLICANT

CONTACT INFORMATION OF MEDICAL DIRECTOR, PHYSICIAN, or REGISTERED NURSE (EXTENDED PRACTICE)/NURSE PRACTITIONER (NP)

Last Name	First Name
Phone Number	E-Mail Address
Position	Practice Site
Name of Extended Practice Pharmacist (EPPh) Applicant	

COLLABORATIVE PRACTICE

Answer the following questions by indicating YES or NO.	**YES**	**NO**
Please confirm that the EPPh applicant will practice in a collaborative practice with either:		
a) Physician(s) or registered nurse(s) (extended practice)/NP, or		
b) With a registered nurse who is not a registered nurse (extended practice)/NP, if the extended practice advisory committee recommended the collaborative practice and its setting and was approved by the minister.		
If the EPPh applicant is to be granted the EPPh designation, please acknowledge and confirm your understanding of the following:		
I understand and acknowledge that patients would be common to myself (and/or the collaborative team) and the EPPh (i.e., there will be a shared provision of care to the mutual patients)		
I understand and acknowledge that I (and/or the collaborative team) would be sharing decision-making, risks and responsibilities in the care of mutual patients with the EPPh.		

Created: September 2021
Amended:

I confirm that the EPPh and I (and/or the collaborative team) have immediate access to relevant diagnostic and health information in order to provide timely and efficient patient care.		
I confirm that there are established procedures for timely communication between myself (and/or the collaborative team) and the EPPh respecting patient care issues and decisions.		

MINIMUM PRACTICE HOUR REQUIREMENT

I confirm that the EPPh Applicant, named above, has engaged in the minimum required practice hours in their area of specialty practice. **Check one:**		**1,000 hours in the past two years**
		5,000 hours in the past five years

Please Note:

1. This declaration is to be made by the Medical Director/Physician/Registered Nurse (Extended Practice)/NP in charge of supporting the EPPh application, whose signature is also on the application. If they are unable to confirm completion of the hour requirements, additional documentation must be provided with the application (e.g., letter from the Human Resources Department or letters from past collaborating prescribers).
2. The hour requirement may only be completed after the EPPh Applicant has received their certification or advanced degree.

PATIENT CARE

How will the addition of the EPPh Applicant augment patient care within the practice site? Please attach additional pages to the application if required.

Do you have any additional comments in support of the above named EPPh Applicant? Please attach additional pages to the application if required.

DECLARATION		
Please respond to the following statements by indicating YES or NO.	**YES**	**NO**
I hereby declare that the information I have provided above is true and correct to the best of my knowledge.		
In my professional opinion, this EPPh Applicant is fit to practice as an Extended Practice Pharmacist competently, safely, and ethically.		
I support this application.		

Signature of supporting Medical Director/Physician/Registered Nurse (Extended Practice/NP)	**Date**