



# College of Pharmacists of Manitoba

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## APPLICATION FOR AUTHORIZATION TO PRESCRIBE A DRUG INCLUDED IN SCHEDULE 3 TO THE PHARMACEUTICAL REGULATION FOR SELF-LIMITING CONDITIONS (NOT INCLUDING SMOKING CESSATION)

I hereby make application to the College of Pharmacists of Manitoba for authorization to prescribe a drug included in the category for a condition (see below) listed in Schedule 3 to the Pharmaceutical Regulation.

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(Title)	(Last Name)	(First Name)	(Middle Name(s))
(Mailing Address)	(City)	(Province)	(Postal Code)
(Telephone Number)	(Email Address)	(College Licence Number)	

### Please read carefully:

To be eligible to apply for certification of authorization to prescribe a drug included in the category for self-limiting conditions listed in Schedule 3 to the Regulation, with the exception of smoking cessation, a pharmacist must:

- be a licensed, practicing member with the College of Pharmacists of Manitoba; and
- have successfully completed the Self-Limiting Conditions Independent Study Program for Manitoba Pharmacists, including viewing the Fundamentals of Self-Limiting Conditions Prescribing for Manitoba Pharmacists presentation.

\*Please note: A certificate of authorization can be issued for either the self-limiting conditions with the exception of smoking cessation; smoking cessation; or for both the self-limiting conditions and smoking cessation. This form is to be completed by applicants who want to prescribe drugs in Schedule 3 to the Regulation for atopic dermatitis, allergic contact dermatitis, irritant contact dermatitis, urticaria; acne vulgaris; tinea pedis; candidal stomatitis; unspecified haemorrhoids without complication; vasomotor and allergic rhinitis; seborrhoeic dermatitis (excluding pediatric); recurrent oral aphthae; and vomiting of pregnancy, unspecified. To apply for authority to prescribe a drug included in Schedule 3 the Regulation for smoking cessation, please see the appropriate application form on [www.cphm.ca](http://www.cphm.ca)\*

To apply to prescribe the drugs for the self-limiting conditions listed in Schedule 3 to the Regulation, with the **exception of smoking cessation**, please attach a copy of the following required document:

- Certificate of successful completion of the Self-Limiting Conditions Independent Study Program for Manitoba Pharmacists, issued by the CPhM

**Professional Declaration**

In the matter of my application to the College of Pharmacists of Manitoba to prescribe a drug included in the category for a condition (with the exception of smoking cessation) listed in Schedule 3 to the Pharmaceutical Regulation

I, \_\_\_\_\_  
(Applicant's Full Name)

of \_\_\_\_\_ in the Province of \_\_\_\_\_ declare that  
(City or Town) (Province)

1. as a regulated member of the College of Pharmacists of Manitoba, licensed as a practicing member, I will abide by the standards of practice, practice directions, and other legislation and requirements that apply to prescribing and restrict my practice to those areas in which I am competent;
2. I am the person referred to in the documents submitted in support of my application, and that these documents present a true and accurate account of my qualifications;
3. I have successfully completed the applicable training program(s) approved by Council and possess the necessary knowledge and skill to prescribe safely and effectively for the self-limiting conditions for which I have applied;
4. the status of my eligibility for certification of authorization to prescribe a drug included in the category for a condition (with the exception of smoking cessation) listed in Schedule 3 to the Pharmaceutical Regulation is subject to audit and that false or misleading statements concerning my qualifications may be considered grounds for a complaint of unprofessional conduct; and
5. I will only prescribe in an area that maintains patient confidentiality and privacy to the extent required.

I make this professional declaration conscientiously believing it to be true.

Declared this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_  
(Date) (Month) (Year) \_\_\_\_\_  
(Signature)