



<b>APPLICANT INFORMATION</b>	
<i>Full Name</i>	<i>Date of Birth</i>
<i>Complete Address</i>	
<i>E-Mail Address</i>	<i>Contact Number</i>
<b>EDUCATION</b>	
<i>University or College</i>	
<i>Address</i>	
<i>PEBC Registration # (5-digit)</i>	<i>Year of Graduation</i>
<b>RESIDENCY TRAINING PROGRAM INFORMATION</b>	
<i>Pharmacy Name</i>	<i>Pharmacy Licence #</i>
<i>Pharmacy Address</i>	
<i>Name of Supervising Pharmacist and License #</i>	<i>Supervising Pharmacist's Signature</i>
<i>Intended Start Date</i>	<i>Intended End Date</i>
<i>Scope of Learning and Training:</i>	
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.....	
.....	



<b>REGISTRATION HISTORY</b>		
<i>Profession</i>	<i>License #</i>	<i>Province/Territory</i>
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<b>SUPPORTING DOCUMENTS</b>		
Please refer to the Academic Register checklist for information on the documents that must be submitted along with this application.		

<b>DISCLOSURES</b>	
<p><b>Please answer the following questions by indicating YES or NO.</b>  <b>If you answer YES to any of the questions, provide details using a separate sheet of paper.</b></p>	
Are you the subject of a current investigation, proceeding, or suspension from practice which relates to your suitability to practice a health profession, including pharmacy, in any jurisdiction in Canada or elsewhere?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has your registration or licence to practice a health profession, including pharmacy, ever been revoked, suspended, restricted, or subject to individual terms or conditions by a regulatory authority in any jurisdiction in Canada or elsewhere?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been subject to an undertaking or formal agreement by a regulatory authority in any jurisdiction in Canada or elsewhere?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been the subject of a finding of conduct unbecoming, or professional misconduct, or incompetence related to the practice of a health profession, including the practice of pharmacy, in any jurisdiction in Canada or elsewhere?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been the subject of a finding of professional negligence or malpractice in any jurisdiction in Canada or elsewhere?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been denied registration by any professional regulatory authority, in any jurisdiction in Canada or elsewhere?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been the subject of a disciplinary finding by any professional regulatory authority, in any jurisdiction in Canada, or elsewhere?	<input type="checkbox"/> YES <input type="checkbox"/> NO



<b>DISCLOSURES</b>	
<p><b>Please answer the following questions by indicating YES or NO.</b>  <b>If you answer YES to any of the questions, provide details using a separate sheet of paper.</b></p>	
Do you currently have a physical or mental condition or disorder, including an addiction to alcohol or drugs, which may impair your ability to engage in professional practice in a safe and effective manner?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been charged, convicted, or found guilty (including conditional discharge, absolute discharge, or suspended sentence) of careless driving causing death under The Highway Traffic Act of Manitoba, or similar legislation?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever been charged, convicted, or found guilty (including conditional discharge, absolute discharge, or suspended sentence) of a criminal or regulatory offence in Canada or elsewhere?	<input type="checkbox"/> YES <input type="checkbox"/> NO

<b>DECLARATIONS</b>	
<p><b>Please respond to the following statements by indicating YES or NO.</b>  <b>If you answer NO to any of the questions, provide details using a separate sheet of paper.</b></p>	
I make application to be placed on the Academic Register of the College of Pharmacists of Manitoba (CPhM) and may be referred to as a "Pharmacy Resident". I understand that I must practice pharmacy under supervision of a licensed pharmacist. My name will remain on the Register for the requested period of time while completing my training program in Manitoba, or until it is removed by Council, or upon my request in writing to be removed in advance of the dated noted.	<input type="checkbox"/> YES <input type="checkbox"/> NO
I hereby certify that I will engage in professional practice competently and with decency, integrity, and honesty and in accordance with the law.	<input type="checkbox"/> YES <input type="checkbox"/> NO
I hereby certify that the statements made by me in this form and all accompanying submissions are complete and accurate to the best of my knowledge and belief. I understand that a false or misleading statement may be referred to the Registrar for further action.	<input type="checkbox"/> YES <input type="checkbox"/> NO
I understand that I must notify CPhM of any changes to the information contained herein and keep my online profile up to date at all times.	<input type="checkbox"/> YES <input type="checkbox"/> NO
By submitting this form electronically, I understand that it represents my signature and is a confirmation of the information provided throughout.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>Applicant's Full Name and Signature</i>	<i>Date Signed</i>