College of Pharmacists of Manitoba

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2025 APPLICATION FOR INITIAL REGISTRATION AS AN EXTENDED PRACTICE PHARMACIST

APPLICANT CONTACT INFORMATION

Last Name	First Name	Middle Name(s)	
Mailing Address	City	Province	Postal Code
Mobile Phone Number	Work Phone Number	Date of Birth (MM / DD / YYYY)	
E-Mail Address		College Licence Number	

SPECIALTY QUALIFICATION

Please refer to the College of Pharmacists of Manitoba website for a list of specialty programs from the Manitoba Pharmaceutical Regulation or approved by Council and the associated practice hour requirements. If you do not see the qualification program listed that you would like to complete for registration as an Extended Practice Pharmacist (EPPh), please email registration@cphm.ca for more information.

Please Note: Practice hours in the specialty area in a collaborative practice setting may be completed prior to, during, or after the licensed pharmacist applicant has received their certification or advanced degree, provided that the pharmacist was practicing independently and autonomously. [i]

Name of Specialty Qualification Program Completed:

Specialty qualification completion and renewal date(s), if applicable:

Name of Specialty:
This is the name of the specialty that will appear on your updated pharmacist license and public profile once you attain the EPPh designation and is subject to review and approval by the Board of Examiners. It must relate to your specialty qualification program completed AND collaborative practice area. A list of specialty names can be found here. You may select more than one, if appropriate.

Created: 03.03.2025
Amended:

COLLABORATIVE PRACTICE SETTING

An EPPh must be in a collaborative practice

(i) with a physician or a registered nurse (extended practice), or

(ii) with a registered nurse who is not a registered nurse (extended practice), if the extended practice advisory committee established under section 99 recommends the collaborative practice and its setting, and the minister approves.

A collaborative practice setting may include a physical, remote, or virtual setting, as long as it is in accordance with all applicable standards, practice directions and laws.

Consistent with the definition of collaborative care in the regulation, applicants for registration as an EPPh are required to confirm that they are in a collaborative practice setting by providing the following information:

Work Location(s) of Collaborative Practice Setting for both EPPh and Collaborating Practitioner(s):

How are personal health records being accessed and stored? Are the requirements of PHIA being met?

Please answer the following questions by indicating YES or NO and provide details in the space provided. Attach additional pages to the application if required.	**YES**	**NO**
a) Patients are common to the pharmacist and the physician or registered nurse (extended practice)/ Nurse Practitioner (NP). i.e., both are providing care to the patient(s).		

Please describe your chosen collaborative practice site, and elaborate on the dynamics of the team, your current and anticipated role within it (an overview of the care provided by you), the demographics of patients, etc**.**

b) The pharmacist and the physician or registered nurse (extended practice)/NP share responsibilities in the care of the common patient(s) and understand their own roles and competence, as well as the roles of each other, and use this knowledge appropriately to establish and meet common patient goals[ii].		

Please describe how a participatory, collaborative and coordinated approach is taken to shared decision-making, and outline the responsibilities and roles of each collaborative team member in the care of patients[iii].

c) The pharmacist and the physician or registered nurse (extended practice)/NP share and/or have timely access to relevant diagnostic and health information.		

Please describe how relevant diagnostic and health information will be shared within this collaborative team and how this information will be accessed by the pharmacist.

d) There are established procedures for timely communication between the pharmacist and the physician or registered nurse (extended practice)/NP respecting patient care issues and decisions.		

Please describe the procedures that will be put in place to ensure timely communication within this collaborative team.

SUMMARY OF CHANGES THAT WILL BE IMPLEMENTED

Please describe any changes that will be implemented in your practice if an EPPh registration is attained, and the expected positive outcomes to patient care. Attach additional pages to the application if required.

DECLARATIONS

Please respond to the following statements by indicating YES or NO.	**YES**	**NO**
I hereby declare that I will meet the annual Continuing Professional Development Requirements and participate in the EPPh Quality Assurance Program.		
I hereby declare that I have kept a three year past record of learning activities in my online professional development profile, through the Registrant Login, and the necessary supportive documents.		
I hereby certify that the statements made by me in this application 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 disqualify me from eligibility to practice or may be case for revocation of a licence to practice that may be granted to me.		
I acknowledge that the EPPh designation is practice site specific, and I understand that I must notify the College in writing as soon as possible if there are any changes to the collaborative practice setting, if I will be leaving the practice site or want to add an additional practice site, if my specialty certification lapses, or if there are any other changes to the information contained herein.		

MINIMUM PRACTICE HOUR REQUIREMENT

All EPPh applicants must confirm that they have practiced at least the minimum required hours in the specialty area in a collaborative practice setting, in the previous two years that includes the specific location(s) where the practice occurred.

Please Note:
The practice hour requirements listed under section 96 (a) to (g) of the Pharmaceutical Regulation, or on the CPhM website, may be completed prior to, during, or after the licensed pharmacist applicant has received their certification or advanced degree, provided that the pharmacist was practicing independently and autonomously. Practice hours completed during entry-to-practice PharmD rotations, internships, residency, MSc., Ph.D., and bridging Pharm D programs are not considered independent and autonomous by the Board of Examiners.

I declare that I have practiced at least the minimum required hours stated in section 96 of the Regulation above in a collaborative practice setting. **Check one:**		**1,000 hours in the past two years**
		5,000 hours in the past five years

I have practiced in the specialty of:

Name and address of practice location(s):

Name	Address
Name	Address
Name	Address

SUPPORTING DOCUMENTS

In support of my application for registration as an Extended Practice Pharmacist, I submit:

1. **A NOTARIZED COPY OF QUALIFYING DEGREE or CERTIFICATE**
   The notarized copy of degree or certificate must display the date first obtained and/or the dates it is valid through. Any previous copies of the certification that display the date it was first attained must also be included.

2. **CURRENT JOB DESCRIPTION/SCOPE OF PRACTICE DESCRIPTION**
   Provide a current job description/scope of practice description and attach it to this application.

FEES & PAYMENT

Registration Fee	$182.00 + $9.10 GST	**TOTAL** **$ 191.10**

When your application is received at the College office, you will be notified by email that an invoice has been generated and is ready for payment.

Payments are accepted by:

1. **Visa or MasterCard**
   If you choose to pay by credit card, you will be advised to pay online through your registrant portal.
2. **Cheque**
   If you choose to pay by cheque, print a copy of the invoice and mail both the invoice and cheque to the College Office. Cheque made payable to the College of Pharmacists of Manitoba

Please Note: All Fees are NON-REFUNDABLE

By signing this application, I attest that:

- The information I provide to the Registrar, herein, is truthful and accurate to the best of my knowledge.
- I will notify the College promptly, in writing, of any changes to information contained herein.

Signature of Applying Pharmacist	**Date**

DECLARATIONS OF COLLABORATING MEDICAL DIRECTOR, PHYSICIAN OR NP IN SUPPORT OF THE APPLICATION

Last Name	First Name
Phone Number	E-Mail Address
Position	Practice Site

By signing this application, I attest that:

- **I am the Medical Director or equivalent supervising the practice setting where the EPPh will be working OR I am the collaborating physician or Registered Nurse Extended Practice in this collaborative practice;**
- **I have reviewed the information contained in this application;**
- **I have informed or will inform all collaborating physicians and practitioners of the EPPh's practice; and**
- **I am supportive of this pharmacist's application as an EPPh as presented.**

Signature of Supporting Physician/NP/Medical Director or Equivalent	**Date**

[i] Practice hours completed during entry-to-practice PharmD rotations, internships, residency, MSc., Ph.D., and bridging Pharm D programs are not considered independent and autonomous by the Board of Examiners.

[ii] Interprofessional Collaborative Care Practice Direction https://cphm.ca/wp-content/uploads/Resource-Library/Practice-Directions-Standards/Interprofessional-Collaborative-Care.pdf

[iii] Adapted from the CIHC National Interprofessional Competency Framework https://phabc.org/wp-content/uploads/2015/07/CIHC-National-Interprofessional-Competency-Framework.pdf