College of Pharmacists of Manitoba

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APPLICATION FOR AUTHORIZATION TO PRESCRIBE FOR UNCOMPLICATED CYSTITIS

APPLICANT CONTACT INFORMATION

Last Name	First Name	Middle Name(s)	
Mailing Address	City	Province	Postal Code
Mobile Phone Number	E-Mail Address		College Licence number

I hereby make application to the College of Pharmacists of Manitoba for authorization to prescribe for uncomplicated cystitis.

Please read carefully:

To be eligible to apply for certification to be authorized to prescribe for uncomplicated cystitis, a pharmacist must:

1. be a licensed, practicing member with the College of Pharmacists of Manitoba;
2. have completed the "Uncomplicated Cystitis Independent Study Program for Manitoba Pharmacists", including the Fundamentals of Prescribing for Manitoba Pharmacists presentation;
3. have read the product monographs of the drugs that the pharmacist is prescribing and reviewed other resources when necessary or appropriate.

To apply to prescribe drugs for uncomplicated cystitis, please attach a copy of the following required document:

❑ Statement of participation for the Uncomplicated Cystitis Independent Study Program for Manitoba Pharmacists, issued by CPhM

PROFESSIONAL DECLARATION

In the matter of my application to the College of Pharmacists of Manitoba to prescribe for uncomplicated cystitis, I declare:	YES	NO
1. As a registrant of the College of Pharmacists of Manitoba, with a practicing license, 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 have successfully completed the required training program(s) approved by Council and possess the necessary knowledge and skill to prescribe safely and effectively for cystitis.		
3. The status of my eligibility for certification to be authorized to prescribe a drug for uncomplicated cystitis is subject to audit; false or misleading statements concerning my qualifications may be considered grounds for a complaint of unprofessional conduct.		
4. I will only prescribe in an area that maintains patient confidentiality and privacy to the extent required.		
5. By signing this application, I make this professional declaration conscientiously believing it to be true.		

Name of Applicant	**City / Town, Province**
Signature of Applicant	**Date**

Updated February 2024