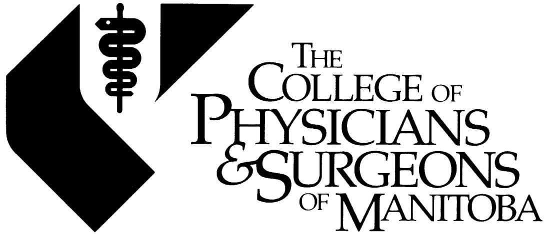

1000-1661 Portage Avenue Winnipeg, Manitoba R3J 3T7
Tel: (204) 774-4344 Fax: (204) 774-0750
E-mail: electives@cpsm.mb.ca

CERTIFICATION BY MEDICAL SCHOOL

APPLICANT MUST COMPLETE THIS SECTION

I, ____, am applying to the College of Physicians and Surgeons of Manitoba, Canada, to practise medicine in the province of Manitoba, and in support of my application I require the medical school from which I graduated or in which I am currently enrolled as a student to certify my graduation and date of degree/diploma or anticipated date of graduation and degree/diploma.

____ ________________________________

Signature of Applicant *Date*

MEDICAL SCHOOL MUST COMPLETE THIS SECTION

I hereby certify that ____
Full name of applicant

graduated/is expected to graduate from

____
Name of Medical School

and received/is expected to receive the degree of ____
Name of Medical Degree/Diploma

on ____
Date degree/diploma conferred/expected to be conferred

____ ________________________________

Signature of Dean or Registrar *Date*

Seal or Stamp of Medical School to be Affixed Here

Note to Medical School: The completed form may be returned by email to electives@cpsm.mb.ca, fax 204-774-0750 or mail

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