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CERTIFICATION OF MEDICAL SCHOOL/UNIVERSITY/COLLEGE GRADUATION

APPLICANT MUST COMPLETE THIS SECTION

I, _____, am applying for registration with the College of Physicians and Surgeons of Manitoba, Canada, and in support of my application I require the medical school/university/college from which I graduated to certify my graduation and date of degree/diploma.

Signature of Applicant

Date

MEDICAL SCHOOL/UNIVERSITY/COLLEGE MUST COMPLETE THIS SECTION

I hereby certify that _____ graduated from
Full name of applicant

_____ and received the degree/diploma of
Name of Medical School/University/College

_____ on _____
Name of Degree/Diploma Date Degree/Diploma conferred

Signature of Dean or Registrar

Date

Note to Medical School/University/College: This form, once completed, must be returned directly to the College of Physicians & Surgeons of Manitoba. The completed form may be returned by facsimile to the College at 204-774-0750. Ensure that the original form is mailed promptly.

Seal or Stamp of
Medical School/
University/College
to be Affixed Here