



THE  
COLLEGE OF  
PHYSICIANS  
& SURGEONS  
OF MANITOBA

1000-1661 PORTAGE AVENUE WINNIPEG, MANITOBA R3J 3T7  
TEL: (204) 774-4344 FAX: (204) 774-0750  
E-MAIL: jstevenson@cpsm.mb.ca; mmiller@cpsm.mb.ca

**CERTIFICATION OF MEDICAL SCHOOL GRADUATION  
(GRADUATES OF CANADIAN AND U.S. MEDICAL SCHOOLS)**

**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 to certify my graduation and date of medical degree.

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date*

**MEDICAL SCHOOL MUST COMPLETE THIS SECTION**

I hereby certify that \_\_\_\_\_ attended  
*Full name of applicant*

\_\_\_\_\_  
*(Name of Medical School)*

from \_\_\_\_\_ to \_\_\_\_\_  
*(date) (date)*

and received the degree of \_\_\_\_\_  
*Name of Medical Degree*

on \_\_\_\_\_  
*Date Medical Degree Conferred*

\_\_\_\_\_  
*Signature of Dean or Registrar*

\_\_\_\_\_  
*Date*

***Note to Medical School: 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 to  
be Affixed Here