THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

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TEL: (204) 774-4344 FAX: (204) 774-0750
E-MAIL: registration@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

2019