APPLICATION FOR SCHOOL CLINICIAN CERTIFICATION

Psychologist	_____	Speech and Hearing	_____	Social Work	_____
Reading	_____	Physiotherapist	_____	Occupational Therapist	_____

Personal Data

Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐		Social Insurance Number (for employment purposes)
Applicant's Surname		Date of Birth (day/month/year)
Given Name(s)(Include maiden name)		Country of Birth (if Outside of Canada)
Previous Name(s)	Telephone Number	Fax Number
Permanent Mailing Address Number and Street		E-Mail Address
City, Town or Post Office	Province	Postal Code
Citizenship/Immigration Status:(attach proof) Canadian Citizen ☐ Landed Immigrant ☐ Valid Work Visa ☐		

Applicant Profile

1. Mother Tongue:	2. Languages of instruction:
3. Languages spoken:	4. I prefer to receive correspondence in: English French

Education History

Secondary:	Diploma or Certificate	School	Location		Year Graduated
University:	Degree/ Program	University	Location	Dates Attended	Year Graduated
1.					
2.					
3.					

Declaration

I authorize the release of information regarding my salary classification, teaching experience and qualifications to school boards, private schools or provincial or federal authorities for employment purposes. I declare that all information on this form is accurate and completed to the best of my knowledge.

_____ Date

_____ Signature

This personal information is being collected under the authority of Manitoba Regulation 515/88 of the Education Administration Act and will be used for ongoing verification of certification and notification. It is protected by the Protection of Privacy provisions of The Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, contact the Program Director at the Professional Certification Unit.

CHECKLIST
Documents Required for School Clinician Certification

	Enclosed	To Follow	Not Applicable
Acceptable Photo Copies			
Birth Certificate			
Change of Name (Marriage Certificate, etc.)			
Proof of Canadian Citizenship or Landed Immigrant Status or Valid Work Visa if born outside of Canada.			
Summary of course descriptions for those courses which are submitted for certification (for all course work completed outside of Manitoba)			
Speech & Hearing/Occupational Therapists or Physiotherapists – verification of registration with your Manitoba association.			
Official Documents			
Official transcripts of all degrees			
Recommendation from last employer or supervisor			
Completed Criminal Record Check			
FORMS			
Claim for Experience			
Official Verification of previous Clinician experience			
Evaluation and certification fee of $60.00 (Payment can be made by cheque or money order payable to the Minister of Finance or by credit card by filling out the credit Card Service request form enclosed)			

If you already hold a Manitoba Teaching certificate, you are not required to submit a Birth Certificate or Social Insurance Number. Some transcripts may already be on file.

THE ONUS IS ON THE APPLICANT TO PROVIDE OFFICIAL VERIFICATION OF QUALIFICATIONS AND EXPERIENCE.

VERIFICATION OF CLINICIAN EXPERIENCE

To be completed by employer:

Full Name Of Clinician:	
Full Address:	
	Postal Code:

The employing authority must complete the following:
Please list by number of days worked in each school year (July-June).

THIS WILL VERIFY that the above clinician was employed:

from	day/	mo/	yr/	**to**	day/	mo/	yr/	total full days

NOTE: 1 FULL DAY EQUALS A MINIMUM OF 5 ½ HOURS.

Please verify the following by circling **Yes or No**

1. The minimum qualifications for certification were necessary for employment; YES NO
2. The employee was under the supervision of a recognized educational authority or qualified clinical authority; YES NO
3. The employing authority was supported by public funds or was eligible for public funds; YES NO
4. Clinical services rendered were relevant to programs offered in the public school system or to the diagnosis and treatment of children with social, emotional, learning and communication disorders; YES NO
5. Brief Job Description (Indicate age of children)

_____

_____

_____

NOTE: **Nursery School and /or pre-Kindergarten experience is acceptable only if all of the above criteria have been met.**

NAME AND ADDRESS OF EMPLOYING AUTHORITY (Please Print)

Signature of Employer	Position:	Date:
Name of Employing Authority (please print)		
Address:		
Postal Code:	Telephone No.:	

Return to: Professional Certification Unit
402 Main Street, P.O. Box 700
Russell MB R0J 1W0
Canada

Ph: 1-204-773-2998
Fax: 1-204-773-2411

This personal information is being collected under the authority of Manitoba Regulation 515/88 of the Education Administration Act and will be used for ongoing verification of certification and notification. It is protected by the Protection of Privacy provisions of The Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, contact the Program Director, Professional Certification Unit.

CLINICIAN EXPERIENCE CHECKLIST

To be completed by Clinician

NAME _____

ADDRESS _____

_____ POSTAL CODE _____

PHONE NUMBER _____

Please list all clinical experience below starting with the first job held:

Dates (month/year)		Employer	Location	Number of Years/Days	Office Use Only
From	To				

NOTE: This experience must be verified officially by your employer to Professional Certification.

_____ _____

Date Signature of clinician applicant

Return to: Professional Certification Unit
402 Main Street, P. O. Box 700
Russell MB ROJ 1WO

This personal information is being collected under the authority of Manitoba Regulation 515/88 of the Education Administration Act and will be used for ongoing verification of certification and notification. It is protected by the Protection of Privacy provisions of The Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, contact the Program Director, Professional Certification Unit.

CREDIT CARD SERVICE REQUEST FORM

If you wish to use your credit card for method of payment, this form must be completed and accompany request.

PROFESSIONAL CERTIFICATION UNIT			
TYPE OF SERVICE	**FEE AMOUNT**	**QUANTITY**	**TOTAL**
Clinician	60.00		
TOTAL			

Method of Payment

Visa ☐	MasterCard ☐

Credit Card Number																	
Cardholder Name													Expiry Date				
Signature																	

For Office Use Only:		
Authorization Number:		
Name:		Receipt Number