

**CONFIRMATION OF PROGRAM COMPLETION**

**INSTRUCTIONS TO THE APPLICANT:**

Please complete section A only and forward the form to the Student Advisor of the Psychiatric Nursing Education program site from which you graduated.

**SECTION A**

Applicant's Name \_\_\_\_\_

I hereby authorize \_\_\_\_\_ of \_\_\_\_\_ to complete section B  
(Name of Educational Institution) (Address of Educational Institution)  
of this form for release to the College of Registered Psychiatric Nurses of Manitoba.

\_\_\_\_\_ Date

\_\_\_\_\_ Applicant's signature

**INSTRUCTIONS TO THE EDUCATIONAL INSTITUTION.**

Please complete **Section B** for the above named applicant, and return this form directly to the College of Registered Psychiatric Nurses of Manitoba. (Not to be sent by the applicant). You may fax this form to (204) 888-8638.

**SECTION B**

The above named states that he/she has completed the requirements for the Psychiatric Nursing Education Program. Please confirm that this is correct by indicating the dates during which the person was in your program.

Month & Year program began: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Month & Year program completed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Status:  Degree student  Diploma Exit  Second Degree  Refresher/Re-entry

Has the applicant completed all of the required components of the program?  Yes  No

To your knowledge, does the applicant suffer from a physical or mental condition, disorder or addiction to alcohol or drugs that could place the safety of the public at risk?  Yes  No

*If you responded "Yes" please provide an explanation on a separate page.*

*Please also complete the following:*

<b>PROFESSIONAL COMPETENCY</b>	<b>Unacceptable</b>	<b>Acceptable</b>
1. Adequate theory base	<input type="checkbox"/>	<input type="checkbox"/>
2. Application of theory to practice	<input type="checkbox"/>	<input type="checkbox"/>
3. Psychiatric nursing intervention skills	<input type="checkbox"/>	<input type="checkbox"/>
<b>EFFECTIVENESS IN INTERPERSONAL RELATIONSHIPS</b>	<b>Unacceptable</b>	<b>Acceptable</b>
1. Forms and maintains effective relationships with clients	<input type="checkbox"/>	<input type="checkbox"/>
2. Forms and maintains effective working relationships with other members of the health team	<input type="checkbox"/>	<input type="checkbox"/>

Date: \_\_\_\_\_

Signature and Title: \_\_\_\_\_