



INTERNATIONAL PHARMACY BRIDGING PROGRAM (IPBP)

Please print clearly in ink and complete all sections

Preferred Location of Program: <input type="checkbox"/> Edmonton <input type="checkbox"/> Calgary
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PART A

LAST NAME		GIVEN NAME(S)	
FORMER NAME (IF LAST NAME AND/OR GIVEN NAMES HAVE CHANGED)			
		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
DATE OF BIRTH (MMM/DD/YYYY)	DATE OF ENTRY TO CANADA (MMM/DD/YYYY)	DATE OF ENTRY TO ALBERTA (MMM/DD/YYYY)	
CITIZENSHIP STATUS			
<input type="checkbox"/> Canadian Citizen		<input type="checkbox"/> Permanent Resident/Landed Immigrant <input type="checkbox"/> Other	
PERMANENT ADDRESS			
Street			
Town/City			
Province	Postal Code	E-mail Address	
Telephone: ()	Cell: ()	Fax: ()	
MARITAL STATUS			
<input type="checkbox"/> Single		<input type="checkbox"/> Married	
<input type="checkbox"/> Cohabiting Partner		<input type="checkbox"/> Separated, Divorced or Widowed	
How many children do you have? _____ How old are they? _____			
What is your country of origin? _____			

PART B

ENGLISH PROFICIENCY	
What is your first language? _____	
Canadian Language Benchmark Assessment (CLBA) Scores:	
Speaking: _____	Listening: _____ Reading: _____ Writing: _____
For statistical purposes only, please indicate the languages in which you are fluent (spoken or written) other than English:	
1. _____ 2. _____ 3. _____	
Have you taken an English language proficiency test in the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide the details below:	
Test: _____	Score: _____ Date completed: (MMM/DD/YYYY)



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PART C

ALBERTA COLLEGE OF PHARMACISTS OF CANADA	
Do you have Intern Registration with the Alberta College of Pharmacists?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Registration Number (attach proof of registration):	
How many hours of Internship have you completed? (proof required)	

PART D

PHARMACY EXAMINING BOARD OF CANADA	
<input type="checkbox"/> Evaluating Exam Date completed : MMM/YYYY	<input type="checkbox"/> Qualifying Exam Part 1 Date completed: MMM/YYYY
Have you ever attempted the Qualifying Exam Part II? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: Number of times taken: _____ Date of last attempt: _____	

PART E

EDUCATION AND TRAINING HISTORY			
Have you taken any training programs in Canada? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, what was the program called? _____			
Are you currently taking a training program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, what program? _____			
What is the highest Education or Training that you have completed to date?			
<input type="checkbox"/> 1 year Diploma	<input type="checkbox"/> 1 year Certificate	<input type="checkbox"/> 2 year Diploma	
<input type="checkbox"/> Applied Degree	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Master's Degree	
<input type="checkbox"/> Doctoral Degree			
How Many years work experience do you have in your profession in your country of origin? _____			
What is your profession (employment goal) in Canada? _____			
PHARMACY DEGREE(S)			
University	Country	Degree Obtained	Dates Attended
			FROM MMM/DD/YYYY TO MMM/DD/YYYY
			Program Type: F/T, P/T (Please circle)
			FROM MMM/DD/YYYY TO MMM/DD/YYYY
			Program Type: F/T, P/T (Please circle)
POST-GRADUATE TRAINING			
University	Country	Degree Obtained	Dates Attended
			FROM MMM/DD/YYYY TO MMM/DD/YYYY
			Program Type: F/T, P/T (Please circle)
			FROM MMM/DD/YYYY TO MMM/DD/YYYY
			Program Type: F/T, P/T (Please circle)
ADDITIONAL POST-SECONDARY EDUCATION OR TRAINING (INCLUDING ESL)			
Educational Institute	Country	Award Obtained	Dates Attended
			FROM MMM/DD/YYYY TO MMM/DD/YYYY
			Program Type: F/T, P/T (Please circle)



			FROM MMM/DD/YYYY TO MMM/DD/YYYY Program Type: F/T, P/T (Please circle)
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PART F

EMPLOYMENT RECORD (STARTING WITH THE MOST CURRENT)		
City and Country	City and Country	City and Country
Employer	Employer	Employer
Position _____ – Avg. hours of work/week _____ Salary (hourly/monthly) _____	Position _____ – Avg. hours of work/week _____ Salary (hourly/monthly) _____	Position _____ Avg. hours of work/week _____ Salary (hourly/monthly) _____
Start: MMM/DD/YYYY End: MMM/DD/YYYY	Start: MMM/DD/YYYY End: MMM/DD/YYYY	Start: MMM/DD/YYYY End: MMM/DD/YYYY
Supervisor	Supervisor	Supervisor
Telephone ()	Telephone ()	Telephone ()
What do you think are your barriers to employment in Canada? (e.g. language, academic, work experience, licensure, etc.) _____ _____ _____		

PART G

FINANCIAL
What is your current major source of income? <input type="checkbox"/> Employment <input type="checkbox"/> Employment Insurance <input type="checkbox"/> Income Support <input type="checkbox"/> AISH <input type="checkbox"/> Student Loan <input type="checkbox"/> Other _____
Have you received EI in the past 3 years? Yes or No (please circle)
Have you received maternity or paternity benefits in the last 5 years? Yes or No (please circle)



DOCUMENT CHECKLIST

Please complete ALL sections below indicating the documents you are submitting in support of your application.

PROOF OF NAME CHANGE
<input type="checkbox"/> Not applicable OR <input type="checkbox"/> Copy of Marriage certificate OR <input type="checkbox"/> Copy of Change-of-Name Document <div style="text-align: center;">AND</div> <input type="checkbox"/> English Translation (if applicable) OR <input type="checkbox"/> English Translation (if applicable)
STATUS IN CANADA
<input type="checkbox"/> Copy of Canadian Citizenship certificate OR <input type="checkbox"/> Copy of Landing Record/ Permanent Resident card
PROOF OF ENGLISH PROFICIENCY
<input type="checkbox"/> Canadian Language Benchmark Assessment (CLBA) OR <input type="checkbox"/> Copy of ACP approved language proficiency test
PHARMACY DEGREE
<input type="checkbox"/> Copy of Pharmacy Diploma/Degree AND <input type="checkbox"/> English Translation (if applicable) <input type="checkbox"/> Copy of other Postgraduate Pharmacy Certificates AND <input type="checkbox"/> English Translation (if applicable)
PEBC EVALUATING EXAMINATION & QUALIFYING EXAMINATION PART 1 RESULTS
<input type="checkbox"/> Copy of letter of results from the PEBC stating successful completion of the EE <input type="checkbox"/> Copy of letter of results from the PEBC stating successful completion of the QEI (if completed) <input type="checkbox"/> Copy of letter of results from the PEBC indicating most recent results of the QEII (if applicable)
RESUME
<input type="checkbox"/> Resume (in English) stating your education, employment and professional history
REFERENCE LETTERS
<input type="checkbox"/> Letter of Reference (employer) Name of Reference: _____ Position: _____ <input type="checkbox"/> Letter of Reference (university instructor or character reference) Name of Reference: _____ Position: _____ <input type="checkbox"/> Letter of Reference (co-worker) Name of Reference: _____ Position: _____
LETTER OF INTENT (minimum of 500 words)
<input type="checkbox"/> I have attached my letter of intent which outlines my reasons for application to the IPB Program
OTHER SUPPORTING DOCUMENTS (e.g. awards/scholarships relevant to application)
<input type="checkbox"/> I have also attached the following documents (Maximum of 3 supporting documents) Please list: 1. _____ 2. _____ 3. _____



Contact Information

This information may be used to contact you during the period of time we have an active file with you. For example, we may contact you to change an appointment, to ask if the services or training have been helpful, or to follow up and audit purposes. We recommend you check with the person(s) whose name and phone number you are providing so that they know you have given permission to ask them for information. The provision of a contact name is voluntary. By providing us with this information you are agreeing that we may contact one or more of these people in the event that we are unable to reach you.

1. Name: _____ Phone Number: _____

Relationship: _____

2. Name: _____ Phone Number: _____

Relationship: _____

Declaration

Please read the following statements carefully and sign (with ink) below.

I certify that:

1. All of the information and documents submitted on my behalf with respect to this application (all of which together constitute "my application") are true, complete and correct
2. All of the information relevant to my application has been included

I agree that if any information or document in my application is false or misleading, or if any relevant information has been concealed, withheld, or not submitted as part of my application, my application may, at the sole option and discretion of the IPBP administration, be rejected, or if I have already been admitted or registered in the program, my admission may, at the sole option and discretion of the IPBP administration, be cancelled or revoked.

Signature: _____ Date (MMM/DD/YYYY): _____



Please Submit To:

Bredin Centre for Learning
c/o International Pharmacy Bridging Program

Attention: Nova Andrews, Program Manager (Edmonton)
5th Floor CN Tower, 10004 – 104 Avenue
Edmonton, Alberta T5J 0K1

Phone: (780) 425-3730 • Toll free: 1-877-273-3461 • Fax: (780) 426-3709

OR

Attention: Raj Neupane, Program Coordinator (Calgary)
Optima Place
#500, 744 – 4th Avenue SW
Calgary, Alberta T2P 3T4

Phone: (403) 261-5775 • Fax: (403) 264-9736

How did you hear about the program?

- Printed advertisement
- Presentation
- Web page
- Friend
- Former/Current IPBP student
- Referred by another program
- Other? _____