



College of
Registered Nurses
of Manitoba

Methadone for Analgesia Application

Name Title Registration #

Address Phone Number Email Address

Employer(s)

Prescribing indication: analgesia **Authority length:** 3 years

Practice setting description (If you work in more than one practice setting where methadone is prescribed, include information for each practice setting, along with the employer and supervisor name for each practice setting):

List all available collaboration and supports (e.g. other methadone providers, laboratory, pharmacy):

Education and training (submit certificate of completion):

Reference #1 (Manager/Supervisor):

Name Title Phone Number

Address Email Address

Reference #2 (name):

Name Title Phone Number

Address Email Address

References will be contacted for information regarding your professional character and accountability

I understand that I am accountable, and it is my professional responsibility to:

- Restrict my practice to that which I am qualified, competent to perform, and is appropriate to my practice area,
- Ensure my practice is compliant with all federal, provincial, and municipal laws, and
- Comply with The Regulated Health Professions Act, RN regulations including Practice Directions.

I _____ certify the information I provide in this document is a true, accurate reflection of my nursing practice. I declare the foregoing information and statements are true in every particular, and I make this declaration conscientiously believing it to be true and knowing it is of the same force and effect as if made under oath.

Signature Date