



**College of
Registered Nurses
of Manitoba**

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Request for Verification of Practice Hours for 2020 Renewal

PART A: Applicant

Complete this section **only**. Have any employers you have worked for in the past five years complete the next section and forward it directly to us. Make copies of this form if necessary.

_____	_____	_____/_____/_____ Date of birth (yy/mm/dd)	
Last name First name			
_____ Address			
_____	_____	_____	_____
City/town Province/state Postal/zip code Country			
_____	_____		
Registration number (if applicable) Email			

I hereby give consent for release of information as requested by the College of Registered Nurses of Manitoba.

_____	_____
Signature Date	

PART B: Employer

Please complete this section and forward the form directly to the College of Registered Nurses of Manitoba.

_____	_____		
Place of employment RN's position/area of responsibility			
_____ Address			
_____	_____	_____	_____
City/town Province/state Postal/zip code Country			
_____	_____		
Phone Email			

Practice Hours

Please state the number of hours this employee has worked as an RN during the past five years. Do not include graduate nurse hours, vacation, sick time or leaves of absence.

2015: _____	2018: _____
2016: _____	2019: _____
2017: _____	

_____	_____
Name Position/Title	
_____	_____
Signature Date	

STAMP OR OFFICIAL SEAL: