College of Registered Nurses of Manitoba

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registration@crnm.mb.ca

Request for Verification of Registration

Part A: Applicant

Applicant: Please complete Part A only and forward this form to the registering/licensing authorities as directed in the instructions. If you require more copies, please photocopy this form. The registering/licensing authority will complete **Part B** and forward the verification directly to the College of Registered Nurses of Manitoba.

Last Name _____ First Name _____ Date of Birth (yy/mm/dd) _____

Address _____

City/Town _____ Province/State _____ Country _____

Postal/Zip Code _____ Home Phone No. _____ Cell Phone No. _____

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: Registering/Licensing Authority

Registering/Licensing Authority: Please complete **Part B** and send directly to the College of Registered Nurses of Manitoba at the address above:

Name of Registering Board/Authority _____

Name of Nursing Education Program _____ Location _____ Graduation Year _____

1. Was the above program an approved nursing education program at the time of completion? YES ❑ NO ❑
2. Initial Registration Date: _____
3. Registered by: ❑ Examination ❑ Endorsement
4. Registration Expiry Date: _____
5. Current Registration Status: ❑ Practicing ❑ Non-practicing ❑ Other _____
6. Is this registration suspended or revoked? YES ❑ NO ❑
7. Does this registration have conditions attached to it? YES ❑ NO ❑
8. Name of Examination written: _____
9. Date of Examination: _____

Name _____ Position/Title _____

Email _____

Signature _____ Date _____

STAMP or
OFFICIAL SEAL