



College of
Registered Nurses
of Manitoba

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crnm.mb.ca

Request for Verification of Practice Hours 2026

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.

Last name First name Date of birth (yy/mm/dd)

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, LPN hours, vacation, sick time or leaves of absence.

| | |
|-------------|-------------|
| 2021: _____ | 2024: _____ |
| 2022: _____ | 2025: _____ |
| 2023: _____ | 2026: _____ |

Name Position/Title

Signature Date

STAMP OR OFFICIAL SEAL: