



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.

2021: _____

2024: _____

2022: _____

2025: _____

Do not include graduate nurse hours, LPN hours, vacation, sick time or leaves of absence.

2023: _____

2026: _____

Name

Position/Title

Signature

Date

STAMP OR OFFICIAL SEAL: