College of Registered Nurses of Manitoba

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Request for Verification of Practice Hours 2023

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, vacation, sick time or leaves of absence.

2018: ____________
2019: ____________
2020: ____________
2021: ____________
2022: ____________

Name ____________ Position/Title ____________

Signature ____________ Date ____________

STAMP OR OFFICIAL SEAL: