College of Registered Nurses of Manitoba

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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: _____

Name _____ Position/Title _____

Signature _____ Date _____

STAMP OR OFFICIAL SEAL: