College of Registered Nurses of Manitoba

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Request for Verification of Practice Hours for RN(NP)s 2024

PART A: Applicant

Complete this section **only**. Have any employers you have worked for in the past three 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(NP)'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(NP) during the past three years. Do not include vacation, sick time or leaves of absence.

2021: _____

2022: _____

2023: _____

Name _____ Position/Title _____

Signature _____ Date _____

STAMP OR OFFICIAL SEAL: