

VERIFICATION OF REGISTRATION

SECTION A – To be completed by applicant and forwarded to the current or most recent regulatory body.

Name: _____ / _____ / _____
First or Given Name Middle Name Surname/Family Name

Other Surname(s) (your surname at birth, your maiden name or other former names): _____

Mailing Address: _____
Post office Box Street Address Apartment/Unit #

City Province/State/County Postal Code Country

Date of Birth: ____/____/____ Registration Number: _____
(month) (day) (year)

I give my consent to you to provide the information requested in Section B or Section C of this form and send it directly to the College of Registered Psychiatric Nurses of Manitoba (CRPNM).

Date

Applicant's Signature

SECTION B – CURRENT REGISTRANTS: To be completed by the regulatory body. Please provide the following information concerning the registration information for the above-named psychiatric nurse and return this form directly to the College of Registered Psychiatric Nurses of Manitoba (CRPNM). **NOTE: THIS IS NOT TO BE SENT BY THE APPLICANT**

FOLLOWING A REVIEW OF THE RECORDS OF THE REGULATORY BODY:

The above named has successfully completed an approved program in psychiatric nursing, and was issued registration Number _____ on _____ (date) Date registration expires or expired: _____

Status of Applicant's Registration: Practicing Non Practicing

Method by which the Applicant was registered: Examination Endorsement

Has the Applicant passed a registration/licensing exam? Yes No Year of Exam: _____

Practice hours for the past 5 years:

Years:					
Hours:					

Are these self-reported hours? Yes No

Does this applicant meet the recency (hours) requirement in your jurisdiction? Yes No

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SECTION C – ELIGIBLE TO REGISTER: *To be completed by the regulatory body.*

FOLLOWING A REVIEW OF THE RECORDS OF THE REGULATORY BODY:

The above named has successfully completed an approved program in psychiatric nursing at:

_____ on ____/____/____
(month) (day) (year)
Name of School

Is the Applicant eligible for registration in your jurisdiction? Yes No

Has the Applicant registered for the RPNCE? Yes No Location: _____ Date: ____/____/____
(month) (day) (year)

Has the Applicant passed the registration/licensing exam? Yes No Year of exam: _____

SECTION D – ALL REGISTRANTS: *To be completed by the regulatory body.*

FOLLOWING A REVIEW OF THE RECORDS OF THE REGULATORY BODY:

Does the registration/license of this psychiatric nurse have any current conditions or limitations? Yes No

Is this psychiatric nurse currently under investigation? Yes No

Has the registration/license of this psychiatric nurse ever been encumbered, revoked, suspended, or denied? Yes No

Does the psychiatric nurse have any physical/mental condition, disorder and/or addiction impairing their ability to practice as a nurse? Yes No

If you answer "Yes" to any of the above questions, please provide details on a separate sheet of paper.

Name (please print your complete name)

Title (please indicate your official title)

Phone number (include country code if outside of Canada)

Email Address



Date

Signature