College of Licensed Practical Nurses of Manitoba

Request for Verification Of Registration

Personal Information:

Name: ______________________________ ______________________________
Last Name First Name

Registration Number: ______________________________ Date of Birth: __ __ /__ __ / __ __ __ __
(Day) (Month) (Year)

Mailing Address:______________________________ City:________________ Province: __________

Postal Code: ________________ Email Address: ______________________________

Cell #: ______________________________ Home #: ______________________________

The CLPNM communicates primarily through email. Please ensure that your contact information is kept up to date.

Please complete this request form and submit it via Canada Post, or email to info@clpnm.ca. Incomplete forms will not be accepted.

Name of Receiving Organization: ______________________________

Address: ______________________________

Declaration: I understand that the verification of registration may include my personal information, my nursing education, my current registration status (including conditions, restrictions, and ongoing investigations), the licensure exam written (including date), and any historical data related to my registration (including past investigations, conditions, or suspensions).

Waiver: I hereby give consent to the CLPNM to provide any information requested for the purposes of registration verification to the organization listed on this request form.

Signature: ______________________________ Date: ______________________________

Fee - $105.00 (All CLPNM Fees are subject to change). Please login to your online CLPNM Alinity account to make payment.

Please do not write in this box – Office Use Only

Payment date: ____________ Taken by: ____________ Payment type: ____________ Reference #:____________

Posted date: ____________ Posted by: ____________ Receipt #: ____________

Date sent/approved: ____________ Completed/approved by: ____________ Alinity: ____________

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