College of Licensed Practical Nurses of Manitoba

Reinstatement Pre-Assessment Information Form

Please fill in the following information and submit this form to the College of Licensed Practical Nurses of Manitoba (CLPNM) by Canada Post, by email, or dropped off in person at the CLPNM office. By submitting this form, I acknowledge that all reinstatement correspondence will be sent to me via email.

1. Date of Reinstatement Request: _____
2. Name: _____
3. CLPNM Registration Number: _____
4. Mailing Address:

   _____

   _____

   _____
5. Phone Number: _____
6. Email Address: _____
7. I have been off of the CLPNM Active Practicing Register for (please check one):

   12 Months or less ☐ 12 months to 8 years ☐ +8 years ☐
8. Have you ever voluntarily surrendered your CLPNM registration? Yes ☐ No ☐
9. The last year I was registered as an LPN: _____

   Name of jurisdiction/regulatory body: _____
10. The last year I practiced as an LPN: _____

    Name of jurisdiction/regulatory body: _____
11. I can confirm that I have 1000 nursing practice hours in the previous 4 years: Yes ☐ No ☐

Declaration:

I, _____, declare that the statements contained in this application are true to the best of my knowledge. Falsification of this application or the submission of any falsified documents to CLPNM is an offence under *The Licensed Practical Nurses Act.*

_____ _____

Signature Date

For Office Use Only Date Rcvd: _____ Pkg Sent: _____ Pkg Sent by: _____

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