



College of Licensed Practical
Nurses of Manitoba

Section A: Personal Information

Name:	_____	_____	_____
	Surname	Given First Name	Surname at time of graduation
Mailing Address:	_____		City: _____
Province:	_____	Postal Code: _____	Email address: _____

Section B: Criminal Record Verification and Child Abuse Registry Check

Submit a current (within one year of date issued) criminal record check and child abuse registry check along with this application.

Section C: Disclosure

Yes	No	Mandatory Questions. Must be answered. If you answered yes to any of the questions please submit documentation.
		Are you currently under investigation and/or have you ever been convicted of an offence under the Criminal Code, Controlled Drugs and Substances Act or Food and Drugs Act?
		Have you ever been denied registration or had a finding by any professional regulatory body?
		Has your registration/license ever been denied, revoked, suspended, restricted or subjected to individual terms and conditions by any regulatory authority in any jurisdiction?
		Are you currently under investigation by any regulatory authority in any jurisdiction?
		Do you have a physical or mental condition, disorder, or addiction to alcohol or drugs that impairs your ability to practice nursing competently and safely?

I certify that the information provided in this disclosure is true and complete.	
_____	_____
Signature of applicant	Date



College of Licensed Practical Nurses of Manitoba

Part 3 Instructions

Please complete Section A and forward to your Licensing Authority. It must be the Licensing Authority that complete Section B and sends it directly back to the College of Licensed Practical Nurses of Manitoba.

Section A: Personal Information

Name: Surname Given First Name Surname at time of graduation
Gender: Male Female
Mailing Address: City:
Province: Postal Code: Email address:
Nursing School Name and location:
Year of graduation: Year registered in original jurisdiction: Registration Number:

Authorization

I authorize the jurisdiction of
to complete this form Date:
Applicant signature

Section B

Licensing Authority

Please complete Section B and send directly back to the College of Licensed Practical Nurses of Manitoba.

Please provide the following:

- 1. Name of Registrant; including all former names used by the registrant
2. Name of nursing program; including program location
3. Nursing program completion date; including day, month and year
4. Whether the program was an approved program at the time the applicant completed
5. Whether the registration was by examination or endorsement; including the name of the exam written
6. The registrants registration number
7. Current Registration type (active practising, non-practising)
8. Registration class (general or advanced register)
9. Initial registration date
10. Current registration status (active practising, non-practising)
11. Registration expiry date
12. Registration history, has this registration ever been denied, revoked, suspended and/or surrendered. If yes please provide documentation.
13. Put a seal of the Licensing Authority on this form.

Licensing Authority Seal

Signature of Licensing Authority Date



College of Licensed Practical Nurses of Manitoba

Section A: Personal Information

Name: Surname Given First Name Surname at time of graduation
Gender: Male Female DOB: MM / DD / YY
Marital Status: Married Single Other
Mailing Address: City:
Province: Postal Code: Email address:
Nursing School Name and location:
Year of graduation: Year registered in original jurisdiction: Registration Number:

Other Registration

Are you or have you ever been registered with any Licensing Authority within the previous seven (7) years other than your initial Licensing Authority?
If yes please fill out Section A and send along with Section B to your other place of registration.
If no please fill out Section A and return to the CLPNM.

Authorization

I authorize the jurisdiction of
to complete this form Date:
Applicant signature

Section B

Licensing Authority

Please complete Section B and send directly back to the College of Licensed Practical Nurses of Manitoba.

Please provide the following:

- 1. Name of Registrant; including all former names used by the registrant
2. Name of nursing program; including program location
3. Nursing program completion date; including day, month and year
4. Whether the program was an approved program at the time the applicant completed
5. Whether the registration was by examination or endorsement; including the name of the exam written
6. The registrants registration number
7. Current Registration type (active practising, non-practising)
8. Registration class (general or advanced register)
9. Initial registration date
10. Current registration status (active practising, non-practising)
11. Registration expiry date
12. Registration history, has this registration ever been denied, revoked, suspended and/or surrendered. If yes please provide documentation.
13. Put a seal of the Licensing Authority on this form.

Licensing Authority Seal

Signature of Licensing Authority Date



**Employer Information
Part 5**

College of Licensed Practical
Nurses of Manitoba

Section A: Personal Information

Name: _____
Surname Given First Name Surname at time of graduation

Mailing Address: _____ City: _____

Province: _____ Postal Code: _____ Email address: _____

Section B: Employed in nursing

Have you ever been employed in nursing? Yes No
If **yes** please fill out Section A and send along with Section C to the place of employment.
(Please note: if you are/were employed in more than one place please contact CLPNM for another form(s)).
If **no** please fill out Section A and return to the CLPNM.

Authorization

I authorize the employer (name of employer) _____
to complete this form _____ Date: _____
Applicant signature

Section C

Employer:
Please complete Section C and send directly back to the College of Licensed Practical Nurses of Manitoba.

Name of Employer Start date (mm/dd/yyyy) End date (mm/dd/yyyy)

Employment: Full time Part time

Hours practised:

Year	Hours
2008	
2009	
2010	
2011	
2012	



College of Licensed Practical
Nurses of Manitoba

Section C cont'd:

Please provide a summary statement for each question.

1. Consistently fulfills professional responsibilities. _____

2. Assesses health status of clients and develops care plans to meet their needs. _____

3. Implements goal directed nursing interventions, evaluates care and modifies the care plan to meet changing needs. _____

4. Effectively uses verbal and non-verbal communication techniques. _____

5. Recognizes and participates in the promotion of health. _____

6. Seeks out learning opportunities to maintain current practice. _____

Competencies: Please identify if the following competencies were part of the applicant's responsibility in your employing agency.

Competencies (state if both theory and clinical were obtained)	Yes	No
Medication Administration/Pharmacology		
Subcutaneous Injections		
Intramuscular Injections		
Urinary Catheterization		
IV Therapy (initiation and maintenance)		
Administering IV Medication (IV piggyback/IV push)		
Central Venous Access Device (CVAD) Therapy		
Blood Administration		
Physical Health Assessment		

Employer Contact Information

Name: _____ Position: _____

Facility: _____ Email address: _____

Address: _____ Phone number: _____

Fax number: _____

Additional comments, if any: _____

Signature: _____ Date: _____



**Verification of Education
Part 6**

College of Licensed Practical
Nurses of Manitoba

Section A:

Name: _____
Surname Given First Name Surname at time of graduate

Mailing Address: _____ City: _____

Province: _____ Postal Code: _____ Email address: _____

Nursing School Name: _____
School name Address Province/State/Country Postal code

Length of program: _____ Program start date: _____ Program completion date: _____
dd/mm/yyyy dd/mm/yyyy

Have you written the Canadian Practical Nurse Registration Examination (CPNRE): Yes No

If yes, please indicate: Location: _____ Year of exam: _____ Result of exam (pass or fail): _____

If no, please indicate the name of the registration exam written: _____ Location: _____

Year of exam: _____ Result of exam (pass or fail): _____

Authorization

I authorize that my school of nursing (name of school) _____
to complete this form _____ Date: _____
Applicant signature

Section B: Verification of Graduation

This information must be filled out a by a Dean at the applicant's school of nursing. It must be signed and dated by the Director and the official seal of the school must be imprinted on all documents. Once completed, the documents must be sent directly to the College of Licensed Practical Nurses of Manitoba.

I _____ certify that the information below is true
Name of Dean (Title if not the Dean)

and accurate for _____
Name of applicant

DOB of applicant: _____
dd/mm/yyyy

Graduated from: _____
Name of Educational Institute City/State/Province

Program length (in months): _____ Program start date: _____ Completion date: _____

Phone number of Dean: _____ Fax number: _____ Email address: _____

School
Seal



College of Licensed Practical
Nurses of Manitoba

Section B cont'd:

Program information required (in English):

1. Attach the applicant's official program transcript.
2. Attach course descriptions, please include theory, clinical course names and hours including length of experience in each clinical area and lab hours.
3. Attach graduate competencies for the programs.

Competencies: Please identify if the following competencies were part of the applicants nursing education program.

Competencies (state if both theory and clinical were obtained)	Yes	No
Medication Administration/Pharmacology		
Subcutaneous Injections		
Intramuscular Injections		
Urinary Catheterization		
IV Therapy (IV initiation and maintenance)		
Preparing and administering IV medications (IV piggyback/IV push)		
Physical Health Assessment		
Central Line Therapy/CVAD		
Obstetrics and Pediatrics		
Blood Administration		

_____ Signature of the Dean	_____ Date
--------------------------------	---------------

School
Seal



College of Licensed Practical
Nurses of Manitoba

Section A: Personal Information

Name: _____
Surname Given First Name Surname at time of graduation

Mailing Address: _____ City: _____

Province: _____ Postal Code: _____ Email address: _____

Is English the language you primarily use for reading, writing, listening and speaking?
 Yes No

If you answered yes to the above question please fill out Section A and return to the College of Licensed Practical Nurses of Manitoba (CLPNM). If you answered no to the above question then English is not considered your first language and you must meet our English language requirements and follow the instructions in **Section B**.

Section B:

An applicant whose first language is not English must provide evidence of fluency in English by taking one of the following:

1. Canadian English Language Benchmark Assessment for Nurses (CELBAN), www.celban.org
2. International English Language Testing System (Academic) (IELTS), or www.ielts.org
3. Test d'évaluation de français (TEF). www.languagecredentials.epsb.ca

Test	CELBAN	IELTS	TEF (Levels 0-6)
Writing	7	7.5 (SEM of 0.5)	4 (Upper intermediate) (SEM 30.5 out of a possible 450)
Speaking	8	7.5 (SEM of 0.5)	5 (Advanced) (SEM 25.44 out of a possible 450)
Listening	10	8 (SEM of 0.5)	5 (Advanced) (SEM 22-24 out of possible 360)
Reading	8	7 (SEM of 0.5)	4 (Upper intermediate) (SEM 20-22 out of possible 300)
Vocabulary and grammar	NA	NA	4 (Upper intermediate) (SEM not available)
Total	NA	7.5 (SEM of 0.5)	NA

Applicant information

Applicant fluency scores will be considered current for two (2) years from the date the test was taken. If the fluency score is not current at the point of issuing a certificate of registration, the applicant may be required to repeat the fluency requirement.

The tests results must be sent from the testing centre directly to the CLPNM.

The English language proficiency requirement must be met prior to your file being processed by the CLPNM.