College of Licensed Practical Nurses of Manitoba

Verification of Education
Part 5

Personal Information:

Name: _____ _____
Last Name First Name

_____ _____
Maiden Name Last Name at time of graduation

Mailing Address: _____ City: _____ Province: _____

Postal Code: _____ Email Address: _____

Cell#: _____ Home#: _____

Name of Nursing Educational Institute: _____

Location of Nursing Educational Institute: _____

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): _____

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

Applicant Authorization:

I authorize _____ to complete this form.
Name of Nursing Educational Institution

Applicant signature: _____ Date: _____

Nursing Educational Institute Instructions:

1. The following sections must be completed by the Dean of the applicant's nursing educational institution.
   NOTE: if the Dean is not available, these sections may be completed by the President, Registrar or Administrator.
2. All documentation must be provided in the English language.
3. Please attach the applicant's official nursing program transcript.
   NOTE: transcripts without marks/grades will not be accepted unless a statement of marks is also provided. If the transcript does not include a breakdown of theoretical and clinical hours, this information must be provided as an additional document.
4. If the applicant graduated from a Canadian nursing program, please attach the course syllabi for the following courses: Physical Health Assessment and IV Therapy. (If the applicant graduated from a nursing program in Québec, course syllabi for Obstetrics and Pediatrics must also be provided in addition to the course syllabi for Physical Health Assessment and IV Therapy)
   NOTE: if these competencies are not taught as individual courses, but as part of other courses, the other course syllabi must also be provided. It must be clearly indicated in which course syllabi the competency(ies) can be located.
   Do Not send course syllabi for nursing programs completed outside of Canada
5. All documents must be mailed directly to the CLPNM. Faxed/scanned documents will not be accepted.

Nursing Educational Institute Contact Information:

I _____ certify that the information below is true and accurate
Name and title

for _____ DOB of applicant: _____
Name of applicant dd/mm/yyyy

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

Program length (in months): _____ Program start date: _____ Program Completion date: _____
dd/mm/yyyy dd/mm/yyyy

Phone number: _____ Email address of Dean (or alternate): _____

Please identify if the following list of competencies were part of the applicant's nursing education program.

Competencies	**Theory**		**Simulation/Lab**		**Clinical**	
	Yes	No	Yes	No	Yes	No
Pharmacology						
Medication Administration (by all routes)						
Subcutaneous Injections						
Intramuscular Injections						
Intravenous (IV) Therapy (IV initiation and maintenance)						
Preparing and administering IV medications (IV secondary/IV push)						
Physical Health Assessment (across the lifespan)						
Central Line (CVAD) Therapy including medication administration						
Maternity/Obstetric Nursing						
Blood Product Administration						
Community Health Nursing						
Pediatric Nursing						

Deans' Authorization

Signature: _____ Date Signed: _____
dd/mm/yyyy

Please Place
Nursing School
Seal Here