



College of Physiotherapists of Manitoba

211-675 Pembina Hwy, Winnipeg, Manitoba, R3M 2L6

Phone: (204) 287-8502 Fax: (204) 474-2506

APPLICATION FOR REGISTRATION AS A PHYSIOTHERAPIST

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Please indicate on which register you are submitting your registration:

14 Active Register \$575.00 **05** Examination Candidate Register \$431.25

34 Inactive Register \$230.00 Temporary Register - Contact CPM

Rates are pro-rated effective August 1. Please call for rates if registering on or after Aug 1.

PERSONAL INFORMATION

CPM Number: (if previously a member) **Please provide an email address on order that we can notify you of newsletters and other important information.**

Surname: _____ Given Name (s): _____

Ms. Mr. Dr. Mrs. Miss Previous Name (s) _____

Address: _____ Postal Code: _____
City: _____
Country: _____

Home Phone: _____ Cell: _____

Primary Email: _____ Alternate Phone: _____

Alternate Email: _____

Gender: Male Female Date of Birth: _____ YYYY / MM / DD

Country of Birth: _____

Initial Employment as a Physiotherapist: Province /State of Registration: _____ Year: _____

Previous Registration: Province/State: _____ Country: _____

LANGUAGE FLUENCY

Please indicate language (s) in which you currently have the ability of providing physiotherapy services.

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ENG English Only

FRE French Only

QTY English & French

OTH Other (Please specify) _____

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May we publicly provide this language information (i.e.: Member Register)? Yes No

PROFESSIONAL REGISTRATION If you are currently registered/licensed to practice as a physiotherapist in another jurisdiction or practice as another health provider, please list below.

Regulatory Body/Other Health Provider: Provide full name (e.g. College of Physical Therapists of Alberta)

LIABILITY INSURANCE COVERAGE

Carrier _____ Amount _____

FOR OFFICE USE ONLY

Amount Paid		Receipt No.		Date		Register	
Payment Type		CPM No.		Members Manual			

EDUCATION

Physiotherapy Education

Credential	Institution Name	Province/Country	Year of Graduation
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Credential Codes: 10 Diploma 20 Baccalaureate 30 Master's 40 Doctorate

Other Physiotherapy Credentials (eg. Acupuncture, Manipulation)

Credential	Institution Name	Province/Country	Year of Graduation
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

10 Diploma 20 Certificate 30 Baccalaureate 40 Master's 50 Doctorate

Education Profile (OTHER)

If you received a **University** Degree/Diploma in Other than Physiotherapy, please complete

Credential	Year	Field of Study Code	School/University	Country of Graduation
<input type="text"/>	YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>

Credential Codes: 10 Diploma 20 Baccalaureate 30 Master's Degree 40 Doctorate

Field of Study Codes:

- | | |
|--|--|
| 010 General Rehabilitation Science | 100 Social Sciences, Arts and Humanities |
| 020 Health Administration/Management | 110 Education |
| 030 Public Administration | 120 Law |
| 040 Public Health | 130 Business, Management, Marketing and Related |
| 050 Kinesiology and Exercise Science | 140 Other Field of Study |
| 060 Gerontology | 150 Massage Therapy |
| 070 Psychology | 160 Spinal Manipulation |
| 080 Health Professions and Related Clinical Sciences | 170 Acupuncture |
| 090 Biological, Biomedical Sciences and Physical Sciences | 999 Unknown |

Physiotherapy Competency Examination (to be completed by new graduates, foreign educated or re-entry applicants).

Component	Date
Written Exam	<input type="text"/>
Practical Exam	<input type="text"/>

Name of Mentor (for new graduates):

Name of Supervising Physiotherapist:
(for re-entry or Foreign-educated applicants)

EMPLOYMENT STATUS IN MANITOBA

<input type="checkbox"/>	14 Employed in Physiotherapy 24 Employed in Physiotherapy, On Leave 34 Employed in Other Than Physiotherapy and Seeking Employment in Physiotherapy 44 Employed in Other Than Physiotherapy and Not Seeking Employment in Physiotherapy 54 Unemployed and Seeking Employment in Physiotherapy 64 Unemployed and Not Seeking Employment in Physiotherapy 74 Employed, Unspecified 84 Unemployed, Unspecified
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EMPLOYMENT INFORMATION

Primary Employment Site

Name of Employer/Business Name:			
Address:		Postal Code:	
Phone:	Fax:	Web site	
Health Region:		Position/Title:	
Employment Start Date:		End Date:	
DD / MM / YYYY		DD / MM / YYYY	
Employment Category	10 Permanent Employee 20 Temporary Employee 30 Casual Employee	34 Employee Unspecified 40 Self-Employed	Employment Full time/Part time Status 10 Full-time 20 Part-time

AREA OF PRACTICE: Check One

<input type="checkbox"/> 014 General Practice	<input type="checkbox"/> 094 Perineal	<input type="checkbox"/> 214 Consultant
<input type="checkbox"/> 024 Sports Medicine	<input type="checkbox"/> 095 Home Care	<input type="checkbox"/> 234 Teaching, Physiotherapy related
<input type="checkbox"/> 034 Burns & Wound Management	<input type="checkbox"/> 100 Other Area of Direct Service	<input type="checkbox"/> 244 Continuing Education
<input type="checkbox"/> 044 Plastics	<input type="checkbox"/> 104 Oncology	<input type="checkbox"/> 254 Other Education
<input type="checkbox"/> 055 Mental Health	<input type="checkbox"/> 110 Administration	<input type="checkbox"/> 264 Sales
<input type="checkbox"/> 054 Amputations	<input type="checkbox"/> 114 Critical Care	
<input type="checkbox"/> 050 Gerontology	<input type="checkbox"/> 120 Client Service Management	
<input type="checkbox"/> 060 Direct Patient Care	<input type="checkbox"/> 124 Cardiology	
<input type="checkbox"/> 064 Orthopaedics	<input type="checkbox"/> 134 Neurology	
<input type="checkbox"/> 065 Womens Health	<input type="checkbox"/> 144 Respiriology	
<input type="checkbox"/> 074 Rheumatology	<input type="checkbox"/> 150 Research	
<input type="checkbox"/> 080 Palliative Care	<input type="checkbox"/> 160 Other Areas of Practice	
<input type="checkbox"/> 084 Vestibular Rehabilitation	<input type="checkbox"/> 174 Return to Work Rehabilitation	
<input type="checkbox"/> 090 Health Promotion and Wellness	<input type="checkbox"/> 184 Ergonomics	

CATEGORY OF PATIENTS/CLIENTS: Check One

<input type="checkbox"/> 24 Paediatric (0-17)	<input type="checkbox"/> 40 Seniors (65+)	<input type="checkbox"/> 50 Other
<input type="checkbox"/> 30 Adult (18-64)	<input type="checkbox"/> 44 All Ages	

CLINICAL/NON-CLINICAL FOCUS OF PRACTICE: Check One

<input type="checkbox"/> 14 Clinical Focus on Musculoskeletal System	<input type="checkbox"/> 54 Clinical Focus on More than One System
<input type="checkbox"/> 24 Clinical Focus on Neurological System	<input type="checkbox"/> 64 Non-clinical Focus
<input type="checkbox"/> 34 Clinical Focus on Cardio Vascular & Respiratory System	
<input type="checkbox"/> 44 Clinical Focus on Skin & Related Structures	

LEVEL OF CARE: Check One

<input type="checkbox"/> 10 Acute	<input type="checkbox"/> 30 Long Term Care
<input type="checkbox"/> 20 Rehab	<input type="checkbox"/> 40 Mixed

PATIENT TYPE: Check One

<input type="checkbox"/> 10 In Patients	<input type="checkbox"/> 30 Mixed
<input type="checkbox"/> 20 Out Patients	

Secondary Employment Site

Name of Employer/Business Name:			
Address:		Postal Code:	
Phone:	Fax:	Web site:	
Health Region:		Position/Title:	
Employment Start Date:		End Date:	
DD / MM / YYYY		DD / MM / YYYY	
Employment Category	<input type="checkbox"/> 10 Permanent Employee <input type="checkbox"/> 20 Temporary Employee <input type="checkbox"/> 30 Casual Employee	<input type="checkbox"/> 34 Employee Unspecified <input type="checkbox"/> 40 Self-Employed	Employment Full time/Part time Status <input type="checkbox"/> 10 Full-time <input type="checkbox"/> 20 Part-time

AREA OF PRACTICE: Check One

<input type="checkbox"/> 014 General Practice	<input type="checkbox"/> 094 Perineal	<input type="checkbox"/> 214 Consultant
<input type="checkbox"/> 024 Sports Medicine	<input type="checkbox"/> 095 Home Care	<input type="checkbox"/> 234 Teaching, Physiotherapy related
<input type="checkbox"/> 034 Burns & Wound Management	<input type="checkbox"/> 100 Other Area of Direct Service	<input type="checkbox"/> 244 Continuing Education
<input type="checkbox"/> 044 Plastics	<input type="checkbox"/> 104 Oncology	<input type="checkbox"/> 254 Other Education
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<input type="checkbox"/> 060 Direct Patient Care	<input type="checkbox"/> 124 Cardiology	
<input type="checkbox"/> 064 Orthopaedics	<input type="checkbox"/> 134 Neurology	
<input type="checkbox"/> 065 Womens Health	<input type="checkbox"/> 144 Respiriology	
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LEVEL OF CARE: Check One

PATIENT TYPE: Check One

<input type="checkbox"/> 10 Acute	<input type="checkbox"/> 30 Long Term Care	<input type="checkbox"/> 10 In Patients	<input type="checkbox"/> 30 Mixed
<input type="checkbox"/> 20 Rehab	<input type="checkbox"/> 40 Mixed	<input type="checkbox"/> 20 Out Patients	

EMPLOYMENT HISTORY

Initial Province of Canadian Employment in Physiotherapy

Name of Employer/Business Name:	
Address:	Postal Code:
Employment Start Date:	End Date:
DD / MM / YYYY	DD / MM / YYYY

DECLARATION STATEMENTS

Please provide particulars if answered Yes

1. <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your license/registration to practice physiotherapy in any province, state or country been cancelled, suspended or not renewed by a regulatory authority?	
2. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had conditions imposed on your physiotherapy license or registration by a regulatory or licensing authority?	
3. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been reprimanded or censured by a physiotherapy licensing authority?	
4. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been notified of any investigations by a regulatory authority against you relative to the practice of physiotherapy?	
5. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a criminal conviction?	
6. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently suffer from a physical or mental condition or disorder for which you have received treatment and which would affect your practice of physiotherapy?	
7. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you suffer from an addiction to alcohol or drugs?	
8. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever undertaken the Physiotherapy Competency Examination? If yes, please provide all examination dates.	
Part 1 (Qualifying examination)		Part 2 (OSCE)
Date (s) _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail		Date (s) _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail
Date (s) _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail		Date (s) _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail
Date (s) _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail		Date (s) _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail

I declare that to the best of my knowledge, the information provided on this form is correct and true.

(Date)

(Signature)

Enclosures Required:

- Proof of Eligibility
 - Evidence of successful completion of the Physiotherapy Competency Examination – Part 1 and/or Part 2
 - Degree from University
 - Confirmation of future employment in Manitoba, stating the date you will be starting work
 - Liability Insurance coverage
 - Criminal record check (**current (within the last 6 months) original**)
- Registration Fees
 - Register Fee as per the enclosed cover letter

Please make remittance for total fees in Canadian Funds payable to: CPM
(Payment options are: cheque, credit card or cash in person)