College of Physiotherapists of Manitoba
1465A Pembina Highway
Winnipeg MB R3T 2C5
P:204-287-8502 Fax: 204-474-2506
info@manitobaphysio.com

Request for Verification of Practice Hours 2025

Part A: Applicant
Complete this section **ONLY**. Have any employers you have worked for in the past five years complete the next section and forward it directly to us. Make copies of this form if necessary.

Last Name | **First Name** | **Date of Birth (YY/MM/DD)**

Address

City/Town | **Province/State** | **Postal/ZIP Code**

Occupation/Business Type

Registration Number (if applicable) | **Email**

I hereby give consent for release of information as requested by the College of Physiotherapists of Manitoba

Signature | **Date**

College of Physiotherapists of Manitoba
1465A Pembina Highway
Winnipeg MB R3T 2C5
P:204-287-8502 Fax: 204-474-2506
info@manitobaphysio.com

Part B: Employer

Please complete this section and forward the form directly to the College of Physiotherapists of Manitoba.

Place of Employment **Physiotherapist's Position/Role**

Address

City/Town **Province/State** **Postal/ZIP Code** **Country**

Phone Number **Email**

Verified Practice Hours

Please state the number of hours this employee has worked as a physiotherapist during the past five years. Do not include vacation, sick time or leaves of absence.

2020: _____ 2021: _____

2022: _____ 2023: _____

2024: _____ 2025: _____

Name **Position/Title**

Signature **Date**

Stamp or Official Seal: