



Centre for Professional Regulatory  
Collaboration  
College of Physiotherapists of Manitoba  
210 Commerce Drive  
Winnipeg, MB R3P 2W1  
P: 204-287-8502 Fax: 204-474-2506  
[info@manitobaphysio.com](mailto:info@manitobaphysio.com)

## Request for Verification of Practice Hours 2026

### 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.

_____	_____	_____
<b>Last Name</b>	<b>First Name</b>	<b>Date of Birth (YY/MM/DD)</b>
_____		
<b>Address</b>		
_____		
_____	_____	_____
<b>City/Town</b>	<b>Province/State</b>	<b>Postal/ZIP Code</b>
_____		
<b>Occupation/Business Type</b>		
_____		
_____	_____	_____
<b>Registration Number (if applicable)</b>	<b>Email</b>	

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

_____	_____
<b>Signature</b>	<b>Date</b>





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## 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.

2021: \_\_\_\_\_

2024: \_\_\_\_\_

2022: \_\_\_\_\_

2025: \_\_\_\_\_

2023: \_\_\_\_\_

2026: \_\_\_\_\_

**Name**

**Position/Title**

**Signature**

**Date**

**Stamp or Official Seal:**

