



Registration Form

Select Register: Active In-active Exam Candidate

Personal Information

Last Name	First Name
Middle Name(s)	Preferred First Name
Previous Name(s)	Gender <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Non-binary <input type="checkbox"/> Unknown <input type="checkbox"/> Another Gender <input type="checkbox"/> Prefer Not to Answer
Date of Birth (DD/MM/YYYY)	Country of Birth
Street Address	City
Province	Postal Code
Country	Email
Home Phone	Cell Phone

The following race-based identifier questions are optional. Please refer to the Collection of Race Based Identifiers FAQ on the CPM website for more information.

Do you identify as an Indigenous person? Select all that apply.

- Prefer not to answer
- First Nations
- Inuk/Inuit
- Métis
- Do not know/Not applicable

What Race, national, or ethnic origin group(s) do you belong to? Select all that apply.

- Prefer not to answer
- Black (African descent, Afro-Caribbean, African Canadian descent)
- East Asian (Chinese, Korean, Japanese, Taiwanese descent)
- Indigenous (First Nations, Inuk/Inuit, Métis descent)
- Latino (Latin American, Hispanic descent)
- Middle Eastern (Arab, Persian, West Asian descent (e.g., Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish))
- South Asian (South Asian descent (e.g., East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean))
- Southeast Asian (Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent)
- White (European descent)
- Another Race category
- Do not know

CAPR Physiotherapy Competency Exam

Have you ever attempted PCE Part 1 (Written Component)? Yes No

If Yes, provide all exam dates:

Exam Date (DD/MM/YYYY)	Result

REQUIRED DOCUMENT

- Create and submit Verification Request Form (VRF) directly through the CAPR client portal to verify completion of the PCE Written and/or Clinical.

Have you ever attempted PCE Part 2 (Clinical Component)? Yes No

If Yes, provide all exam dates:

Exam Date (DD/MM/YYYY)	Result

REQUIRED DOCUMENT

- Create and submit Verification Request Form (VRF) directly through the CAPR client portal to verify completion of the PCE Written and/or Clinical.

Clinical Evaluation in a Canadian Jurisdiction

Have you ever attempted a Clinical Evaluation in another Canadian Jurisdiction? Yes No

If Yes, provide all exam dates:

Jurisdiction	Clinical Evaluation Name	Result Date (DD/MM/YYYY)	Result

CAPR Canadian Physiotherapy Examination (CPTE)

Have you ever attempted the CAPR Canadian Physiotherapy Examination (CPTE)? Yes No

If Yes, provide all exam dates:

Exam Date (DD/MM/YYYY)	Result

REQUIRED DOCUMENT

- Create and submit Verification Request Form (VRF) directly through the CAPR client portal to verify completion of the CPTE.

Spoken/Written Languages (Other Than English)

You may include other languages *in which you can provide physiotherapy services* here:

Do you grant CPM permission to share this information with members of the public? Yes No

Education

Physiotherapy Education

REQUIRED DOCUMENT

- Submit a copy of your Physiotherapy Degree to CPM

All university-level physiotherapy education:

Credential Type (Diploma, Baccalaureate, Masters, Doctorate)	Institute Name	Province	Country	Graduation Date (DD/MM/YYYY)

Bridging Program

If you are Internationally Educated, have you completed a Bridging Program? Yes No

If Yes, please enter your Bridging Program information below:

Institute and Course Name	Province	Graduation Date (DD/MM/YYYY)

Other Education

University-level education other than physiotherapy:

Credential Type (Diploma, Baccalaureate, Masters, Doctorate)	Institute Name	Area of Study	Province	Country	Graduation Date (DD/MM/YYYY)

Regulatory History

Physiotherapist

List all provinces/territories/countries where you have worked as a physiotherapist:

Registration Number	Regulator or Association Name	Organization Province/Country	Effective Date (DD/MM/YYYY)	Expiry Date (DD/MM/YYYY)

Other Regulated Professional

List all provinces/territories/countries where you have worked as another regulated professional:

Registration Number	Regulator or Association Name	Organization Province/Country	Effective Date (DD/MM/YYYY)	Expiry Date (DD/MM/YYYY)

REQUIRED DOCUMENT

- Arrange for submission of a Regulatory History Form from the last two Regulators/Associations where you were registered. The Regulatory History Form should be sent directly from the regulator to CPM*. *This document may not be required for In-active registrants returning to Active after a leave where they did not work in another province; please contact CPM to confirm.

Practice Hours

Practice Hours are hours worked in physical therapy practice. This includes clinical practice, Physical Therapy administration, teaching, management, research and consultation where the knowledge, skills and abilities of a Physical Therapist constitutes the basis for the job responsibilities.

Practice Hours include hours worked in other jurisdictions.

Practice Hours do NOT include continuing education, volunteer work, professional association or college activities, vacation leave, sick leave, family leave, leave of absence, education leave or statutory holiday hours.

Total Practice Hours from within the last five years: _____

REQUIRED DOCUMENT

- Arrange for Request for Verification of Practice Hours Form to be completed by previous employer(s) and sent directly to CPM*. *This document will be requested prior to the first registration renewal after initial registration (or re-registration) with CPM if registering under Labour Mobility.

Professional Liability Insurance Coverage

You require a minimum of \$5 million in Professional Liability Insurance (also known as Errors and Omissions Insurance). You must provide confirmation of your insurance coverage, such as a certificate of insurance or confirmation stated in your Letter of Offer.

Have you acquired Professional Liability Insurance Coverage of \$5 million or more? Yes No

Insurance Carrier _____ Amount (minimum \$5 million) _____

My employer provides insurance Yes No

REQUIRED DOCUMENT

- Submit confirmation of your Professional Liability Insurance Coverage such as a certificate of insurance or confirmation stated in your Letter of Offer.

I understand that I must always have professional liability insurance coverage while I am registered, and I must make sure that I am covered for EACH of my PT positions and PT volunteer work.

Employment Status

Do you have employment in physiotherapy in Manitoba? Yes No

If you do not have employment in Manitoba, please choose your employment status from the following options:

- | | |
|---|---|
| <input type="checkbox"/> Employed in another province | <input type="checkbox"/> On parental leave |
| <input type="checkbox"/> Unemployed | <input type="checkbox"/> On maternity leave |
| <input type="checkbox"/> On leave from work | <input type="checkbox"/> On paternity leave |
| <input type="checkbox"/> On unpaid leave of absence | <input type="checkbox"/> On short-term disability |
| <input type="checkbox"/> On unpaid leave of absence | <input type="checkbox"/> On long-term disability |
| <input type="checkbox"/> Retired | |

If you are not employed as a physiotherapist, are you seeking employment in or outside the profession?

- Seeking employment in physiotherapy
- Not seeking employment in physiotherapy
- Not seeking employment

REQUIRED DOCUMENT

- Submit a Letter of Offer of employment (with start date, on clinic/facility letterhead) to CPM*.
- *this document will be requested within 3 months from date of initial registration (or re-registration) with CPM if registering under Labour Mobility.

Primary Employment

Organization Name	
Organization Street Address	
Organization City	Organization Phone
Employment Start Date (DD/MM/YYYY)	Supervisor Name
Position Title	

Employment Type – select one <input type="checkbox"/> 10 Permanent employee <input type="checkbox"/> 40 Self-employed <input type="checkbox"/> 20 Temporary employee <input type="checkbox"/> 34 Other		Employment FT/PT/Casual Status – select one <input type="checkbox"/> 10 Full time <input type="checkbox"/> 20 Part Time <input type="checkbox"/> 30 Casual	
Employment Preference– select one I would prefer to have <input type="checkbox"/> 10 Full time <input type="checkbox"/> 20 Part Time <input type="checkbox"/> 30 Casual employment			
Employment Position/Role – select one			
<input type="checkbox"/> 10 Administrator <input type="checkbox"/> 12 Analyst <input type="checkbox"/> 14 Case Manager <input type="checkbox"/> 16 Chief Executive Officer/Registrar <input type="checkbox"/> 26 Consultant		<input type="checkbox"/> 28 Coordinator <input type="checkbox"/> 30 Direct Care Provider <input type="checkbox"/> 32 Director/Assistant Director <input type="checkbox"/> 34 Educator <input type="checkbox"/> 38 Manager/Assistant Manager	
		<input type="checkbox"/> 44 Owner/Operator <input type="checkbox"/> 48 Professional Leader <input type="checkbox"/> 54 Researcher <input type="checkbox"/> 58 Supervisor <input type="checkbox"/> 69 Other	
Areas of Practice – select up to three areas of practice that account for majority of hours worked (rank them 1,2,3)			
<input type="checkbox"/> 112 Amputation care ___ <input type="checkbox"/> 116 Burns care ___ <input type="checkbox"/> 118 Cardiology ___ <input type="checkbox"/> 120 Chronic disease ___ <input type="checkbox"/> 122 Chronic pain ___ <input type="checkbox"/> 126 Cognitive disorders ___ <input type="checkbox"/> 128 Critical care ___ <input type="checkbox"/> 130 Developmental habilitation/disabilities ___ <input type="checkbox"/> 134 Diabetes care ___ <input type="checkbox"/> 138 Emergency care ___ <input type="checkbox"/> 142 Ergonomics ___ <input type="checkbox"/> 150 General practice ___ <input type="checkbox"/> 154 Geriatrics ___ <input type="checkbox"/> 158 Hand therapy ___ <input type="checkbox"/> 160 Health promotion ___		<input type="checkbox"/> 168 Maternity/newborn ___ <input type="checkbox"/> 170 Mental health care ___ <input type="checkbox"/> 174 Musculoskeletal ___ <input type="checkbox"/> 178 Neurology ___ <input type="checkbox"/> 182 Occupational health ___ <input type="checkbox"/> 184 Oncology ___ <input type="checkbox"/> 192 Orthopedics ___ <input type="checkbox"/> 194 Palliative care ___ <input type="checkbox"/> 196 Pathology ___ <input type="checkbox"/> 198 Patient safety ___ <input type="checkbox"/> 200 Pediatrics ___ <input type="checkbox"/> 206 Primary care ___ <input type="checkbox"/> 208 Public health and prevention ___ <input type="checkbox"/> 212 Pelvic health ___ <input type="checkbox"/> 214 Physical medicine and rehab ___ <input type="checkbox"/> 218 Respiriology ___	
		<input type="checkbox"/> 220 Rheumatology ___ <input type="checkbox"/> 222 Sports medicine ___ <input type="checkbox"/> 230 Vestibular rehabilitation ___ <input type="checkbox"/> 234 Wound management service ___ <input type="checkbox"/> 236 Administration ___ <input type="checkbox"/> 238 Health policy ___ <input type="checkbox"/> 240 Regulation ___ <input type="checkbox"/> 242 Supervision ___ <input type="checkbox"/> 248 Client service management ___ <input type="checkbox"/> 250 Staff education ___ <input type="checkbox"/> 252 Client/patient education ___ <input type="checkbox"/> 254 Institutional education ___ <input type="checkbox"/> 256 Research ___ <input type="checkbox"/> 260 Sales ___ <input type="checkbox"/> 269 Other areas of practice not otherwise specified ___	
Virtual Care Work Ratio – please enter the proportion of virtual care services to deliver direct care (select one)			
<input type="checkbox"/> 10 More than 50% of the time <input type="checkbox"/> 15 10% to 49% of the time		<input type="checkbox"/> 20 Less than 10% of the time <input type="checkbox"/> 25 Never	
Method Care /Interaction Type - select up to three methods of interaction that account for the majority of hours worked (rank them 1,2,3)			
<input type="checkbox"/> 10 In person ___ <input type="checkbox"/> 15 Email ___ <input type="checkbox"/> 25 Telephone ___		<input type="checkbox"/> 30 Videoconference ___ <input type="checkbox"/> 39 Other _____	

Secondary Employment

Organization Name	
Organization Street Address	
Organization City	Organization Phone
Employment Start Date (DD/MM/YYYY)	Supervisor Name
Position Title	

Employment Type – select one <input type="checkbox"/> 10 Permanent employee <input type="checkbox"/> 40 Self-employed <input type="checkbox"/> 20 Temporary employee <input type="checkbox"/> 34 Other		Employment FT/PT/Casual Status – select one <input type="checkbox"/> 10 Full time <input type="checkbox"/> 20 Part Time <input type="checkbox"/> 30 Casual	
Employment Preference– select one I would prefer to have <input type="checkbox"/> 10 Full time <input type="checkbox"/> 20 Part Time <input type="checkbox"/> 30 Casual employment			
Employment Position/Role – select one			
<input type="checkbox"/> 10 Administrator <input type="checkbox"/> 12 Analyst <input type="checkbox"/> 14 Case Manager <input type="checkbox"/> 16 Chief Executive Officer/Registrar <input type="checkbox"/> 26 Consultant		<input type="checkbox"/> 28 Coordinator <input type="checkbox"/> 30 Direct Care Provider <input type="checkbox"/> 32 Director/Assistant Director <input type="checkbox"/> 34 Educator <input type="checkbox"/> 38 Manager/Assistant Manager	
		<input type="checkbox"/> 44 Owner/Operator <input type="checkbox"/> 48 Professional Leader <input type="checkbox"/> 54 Researcher <input type="checkbox"/> 58 Supervisor <input type="checkbox"/> 69 Other	
Areas of Practice – select up to three areas of practice that account for majority of hours worked (rank them 1,2,3)			
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		<input type="checkbox"/> 220 Rheumatology ___ <input type="checkbox"/> 222 Sports medicine ___ <input type="checkbox"/> 230 Vestibular rehabilitation ___ <input type="checkbox"/> 234 Wound management service ___ <input type="checkbox"/> 236 Administration ___ <input type="checkbox"/> 238 Health policy ___ <input type="checkbox"/> 240 Regulation ___ <input type="checkbox"/> 242 Supervision ___ <input type="checkbox"/> 248 Client service management ___ <input type="checkbox"/> 250 Staff education ___ <input type="checkbox"/> 252 Client/patient education ___ <input type="checkbox"/> 254 Institutional education ___ <input type="checkbox"/> 256 Research ___ <input type="checkbox"/> 260 Sales ___ <input type="checkbox"/> 269 Other areas of practice not otherwise specified ___	
Virtual Care Work Ratio– please enter the proportion of virtual care services to deliver direct care -select one)			
<input type="checkbox"/> 10 More than 50% of the time <input type="checkbox"/> 15 10% to 49% of the time		<input type="checkbox"/> 20 Less than 10% of the time <input type="checkbox"/> 25 Never	
Method Care /Interaction Type - select up to three methods of interaction that account for the majority of hours worked (rank them 1,2,3)			
<input type="checkbox"/> 10 In person ___ <input type="checkbox"/> 15 Email ___ <input type="checkbox"/> 25 Telephone ___		<input type="checkbox"/> 30 Videoconference ___ <input type="checkbox"/> 39 Other _____	

Declarations

1. Has your license/registration to practise physiotherapy in any province, state or country been cancelled, suspended or not renewed by a regulatory authority?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details	
2. Have you ever had conditions imposed on your physiotherapy licence or registration by a regulatory or licensing authority, other than by the College of Physiotherapists of Manitoba?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details	
3. Have you ever been reprimanded or censured by a physiotherapy licensing authority, other than by the College of Physiotherapists of Manitoba?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details	
4. Have you been notified of any investigations by a regulatory authority against you relative to the practice of physiotherapy, other than by the College of Physiotherapists of Manitoba?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details	
5. Have you ever been denied registration by a regulatory body/association in a regulated or unregulated profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details	
6. Have you ever had a complaint submitted to the Commissioner of Teacher Professional Conduct through the <i>Education Administration Act</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details	

7. Have you ever had a criminal conviction? (Have you ever been charged, convicted or found guilty (i.e. conditional discharge, absolute discharge or suspended sentence) of a criminal offence?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details	
8. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details	
9. Do you have an addiction to alcohol or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details	
10. I agree to inform the College of Physiotherapists of Manitoba (CPM) of the results of any Clinical Evaluation attempt in another province.	<input type="checkbox"/> Yes Initial here:

Submission of Documents

Documents can be submitted by email to registration@manitobaphysio.com or by fax to 204-474-2506.

<p>OTHER REQUIRED DOCUMENTS</p> <ul style="list-style-type: none"> • Submit a nationwide Criminal Record Check with Vulnerable Sector Check from the jurisdiction where you currently reside, as well as from all countries that you resided in during the six months prior to submitting an application for registration*. *This document may not be required for In-active registrants returning to Active after a leave in which they did not live in another province; please contact CPM to confirm.

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

Date _____ Signature _____