

In Good Standing Certificate

Please forward this in good standing certificate request to each Regulatory Body you have been registered, licensed or certified with as a social worker or any profession. Some Regulators charge a fee to complete this form, which is the responsibility of the applicant.

CONSENT TO DISCLOSE INFORMATION

I, _____ authorize the _____
 (Your Name) (Name of Regulator)
 to provide the following information to the Manitoba College of Social Workers.

PERSONAL INFORMATION

Last Name: _____ First Name: _____

Other Names Used: _____ DOB (mm/dd/yyyy): _____

Mailing Address: _____

City: _____ Province: _____ Country: _____

Signature

Date

**DIRECTIONS FOR REGULATORS: Please complete and return this form directly to
 Manitoba College of Social Workers: 101-2033 Portage Avenue, Winnipeg, MB R3J 0K6**

1. Does this individual currently hold a certificate of practice, license or permit to practice social work with your regulatory body? Yes No

Registration category details (e.g., Practicing, Non-Practicing, Active/Inactive, General etc.):

Registration #: _____

From: _____ To: _____
 Start Date End Date

Current Status of Registration: Active Expired Cancelled Other, please explain:

2. Are there any limits or conditions on the individual's registration/licensure?

Yes No

If yes, please explain:

3. Is the individual current in respect to obligations owed to you? (payment of fees, continuing competence program requirements, any legislated requirements for registration etc.)

Yes No

If no, please explain:

4. Is the individual currently or ever been the subject of a complaint and/or disciplinary action?

Yes No

If yes, please provide information including any allegations, findings, particulars of the grounds for the findings, orders and penalties, if applicable, and a copy of any decisions.

5. Please provide any other information that your organization can share about this individual that might affect a decision to register or license this registrant as a social worker.

SOCIAL WORK REGULATOR INFORMATION

Regulatory Body: _____

Mailing Address: _____

City: _____ Province: _____ Country: _____

FORM COMPLETED BY

Last Name: _____ First Name: _____

Title: _____ Email Address: _____

Signature: _____ Date: _____

SOCIAL WORK REGULATOR SEAL