Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us/

INFORMATION FOR LICENSED PRACTICAL NURSES LICENSURE BY EXAMINATION

REQUIREMENTS FOR EXAMINATION CANDIDATES

An applicant is eligible for the examination for practical nurses if the applicant has graduated from a board-approved school of practical nursing; has completed 2 years of high school or its equivalent and does not have an arrest or conviction record, subject to the Fair Employment Act. *(See attached Convictions and Pending Charges-Form #2252.)*

Applicants who have graduated from a school of practical nursing outside of the United States or a U.S. territory are required to take and satisfactorily complete a board-approved qualifying examination by the "Test of English as a Foreign Language" (TOEFL) prior to admission to the NCLEX. **Exemption:** If English was the primary spoken and written language of instruction and communication in your school of practical nursing, you are exempt from the TOEFL requirement.

The NCLEX is being administered year-round via Computerized Adaptive Testing (CAT). Your eligibility for examination will be determined by the Board of Nursing upon receipt of a completed application and all supporting documents in the board office.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

1. **Application (Form #738):** Complete the enclosed application and attach the appropriate fee. Make check payable to "Department of Regulation & Licensing". Mail to the Board of Nursing at P.O. Box 8935, Madison, WI 53708-8935. *See page 2 of this application for other required documents.*

2. **Statement of Graduation (Form #259)** *("Board-approved school" U.S. or U.S. territory)*: Complete and forward to your board-approved school of nursing. *This form must be returned directly* to the Board of Nursing, at P.O. Box 8935, Madison, WI 53708-8935. Forms received from the applicant will be rejected by the board. This form should not be completed by your school of nursing until you have actually graduated. Anticipated dates of graduation will not be accepted. *Official transcripts are not required.* If the school you graduated from is closed, contact the Department of Public Instruction in the state where you graduated to determine where the records for the closed school were transferred.

3. **Statement of Foreign Nursing Education (Form #1006)** *(Foreign graduates only including Canada)*: Complete and forward to your board-approved school of nursing. *This form must be returned directly* to the Board of Nursing at P.O. Box 8935, Madison, WI 53708-8935. Forms received from the applicant will be rejected by the board. This form should not be completed by your school of nursing until you have actually graduated. Anticipated dates of graduation will not be accepted.

4. **TOEFL Report Required** *(Foreign graduates only)*: Contact the "Test of English as a Foreign Language" at P.O. Box 6151, Princeton, NJ 08541-6151 to *request a copy of test result scores be sent directly* to the Board of Nursing, P.O. Box 8935, Madison, WI 53708-8935. **Certificates received from the applicant will be rejected by the board.**

5. **Temporary Permit (Form #2433) (optional):** Complete the top portion of Form #2433. The Statement must be completed by your R.N. supervisor. Return this form to the board office with your application and appropriate fee.

NCLEX CANDIDATE BULLETIN

Complete the NCLEX registration form according to the instructions provided in the enclosed "NCLEX Candidate Bulletin". Attach the appropriate fee (*certified check, cashier's check or money order only)* made payable to the "National Council of State Boards of Nursing" and *forward directly to NCLEX in the envelope provided.*

State of Wisconsin Department of Regulation & Licensing

TEMPORARY PERMIT

An applicant for L.P.N. licensure who has graduated from a board-approved school of practical nursing may be eligible for a temporary permit upon submission of a completed application, supporting documents, credential fee, exam fee, and temporary fee. To maintain eligibility, an applicant shall schedule and take the examination prior to the expiration date of the temporary permit. An applicant who has failed a licensing examination in any state may apply for admission to take the NCLEX in Wisconsin, but shall not be eligible for a temporary permit.

A temporary permit is good for a period of 90 days or until the holder receives notification of failing NCLEX. The permit shall be returned by the holder to the board immediately. Failure to return the permit promptly shall, without further notice or process, result in a board order to revoke the permit. Temporary permits are non-renewable.

An applicant for L.P.N. licensure who holds a valid permit under this section or sec. N 3.05(4)(b), may use the title "graduate practical nurse" or the letters "G.P.N." and shall not practice beyond the scope of the license the holder is seeking to obtain. The holder is required to practice under the direct supervision of an R.N. (The supervisor must be on-site and immediately available at all times.)

You may not practice as a licensed practical nurse in Wisconsin unless you have either a permanent license or temporary permit.

AMERICANS WITH DISABILITIES ACT

The department complies with the Americans With Disabilities Act of 1990. The department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

REQUESTS FOR EXAMINATION MODIFICATIONS FOR PERSONS WITH DISABILITIES

Candidates must indicate at the time of application to the department that modifications are being requested. Requests must include a specific description by the candidate of requested modifications, a letter of diagnosis of specific disability from a qualified professional, and a letter from the nursing education program indicating what modifications were granted by the program. Request forms are available at (608) 266-2852 or TTY at (608) 267-2416.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

MAILING INSTRUCTIONS

Mail the application, the appropriate fee, and supporting documentation to the following address:

DEPARTMENT OF REGULATION & LICENSING
BOARD OF NURSING
P.O. BOX 8935
MADISON, WI 53708-8935

Department of Regulation & Licensing

State of Wisconsin
(608) 266-0145
TTY# (608) 267-2416] hearing or speech
TRS# 1-800-947-3529] impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 261-7083

OFFICE OF EXAMINATIONS

REQUESTS FOR EXAMINATION MODIFICATIONS

Candidates requesting modifications to examinations to accommodate disabilities are asked to submit the following documentation regarding the disability: a letter from the candidate requesting modifications, a letter of diagnosis from a qualified professional with expertise in the area of the diagnosed disability and a letter from the nursing education program indicating what modifications, if any, were granted by that program.

- The letter from the candidate should be as specific as possible indicating how much additional testing and/or break time is needed, as well as other modifications such as a reader, writer, special equipment, etc. A history of prior modifications made by schools or other test providers should be included.

- The letter from the qualified professional should include a recent diagnosis, specific findings in support of the diagnosis, a description of the individual's functional limitations due to the stated disabilities, and specific recommendations for test modifications including a detailed explanation of why the modification is needed. For candidates with learning disabilities, the professional documentation should include identification of the specific standardized and professionally recognized test assessments given (e.g., Woodcock-Johnson, Weschler Adult Intelligence Scale).

- The letter from the nursing education program should include a specific description of what modifications were provided by the program.

Many initial requests have not been supported by sufficient documentation. This has resulted in delays in testing while further documentation is obtained. The documentation is necessary to fairly determine a reasonable and appropriate modification for the candidate.

Modifications will be made on an individual basis and depend on the nature and extent of the disability, documentation provided, and the requirements of the examination. The Department will provide qualified examinees who have documented disabilities with appropriate auxiliary aids and services that do not fundamentally alter the measurement of the skills or knowledge the examination is intended to measure and that would not result in an undue burden to the state.

Documentation is the responsibility and cost of the candidate, but the modification and its cost is the responsibility of the Department and the National Council of State Boards of Nursing.

Candidates must indicate at the time of application that modifications are being requested. Any documentation that does not accompany the initial application should be sent directly to:

Office of Examinations
Wisconsin Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53711

Please feel free to call the Department's Office of Examinations at 608-266-0405 if you have questions about this requirement.

#2360 (Rev. 2/01)
Ch. 440.04(7), Stats.

Wisconsin Department of Regulation & Licensing

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LICENSED PRACTICAL NURSE
LICENSURE BY EXAMINATION APPLICATION
BOARD OF NURSING

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth
_____ month _____ day _____ year

Daytime Telephone Number
( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Nursing School: _____

School Address: _____
(City) (State)

Graduation Date: _____ month _____ day _____ year

Type of Degree: _____

What is your state of primary residence?

_____

If not Wisconsin, do you plan to move to Wisconsin and take up primary residence?

☐ **Yes** ☐ **No**

APPLICATION FEES

Make check payable to Department of Regulation and Licensing and attach to application.

☒ $ 53.00 Initial License Fee
$ 15.00 Contract Exam Fee
$ 68.00 Total Fee Attached

CHECK BOX FOR TEMPORARY PERMIT

☐ **$ 10.00** in addition to the above fee (*non-refundable*)

For Receipting Use Only

#738 (Rev. 02/02)
Ch. 441, Stats.

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

1. Fee(s) attached to this completed 5 page application (Form #738).
2. Statement of Graduation from Nursing School (Form #259). (U.S. graduates only.)
3. Verification of licensure (Form #741) (include active and inactive licenses). See below.*
4. Conviction and Pending Charges (Form #2252) (if applicable).
5. Copies of malpractice suit(s). Submit copy of court documents of criminal complaint and judgment of conviction (if applicable).
6. Statement of Foreign Nursing Education (Form #1006). (Foreign graduates only.)
7. TOEFL score report if English was not the primary language of instruction. (Foreign graduates only.)

PRACTICE: Account for all activities and practice from date of graduation to the present time. **Must include professional and non-professional activities. ALL dates and time must be accounted for.** (Attach additional sheets if necessary)

	EMPLOYER/ACTIVITY	CITY/STATE	DATES (from - to) mo/yr
1.			
2.			
3.			
4.			
5.			
6.			

I AM, OR HAVE BEEN, LICENSED IN THE FOLLOWING STATES (Include all active and inactive states):

By Written Exam: _____

By Endorsement/Reciprocity: _____

***Verification of each license you currently hold or have held is required in writing from every state board. To verify a license from a compact state use enclosed form from Nur*sys*. For verification of all licenses in other states use From #741.**

Wisconsin Department of Regulation & Licensing

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

		YES	NO
1.	Have you ever had a finding of abuse or misappropriation placed against you on the Wisconsin Nurse Aide Registry of the Department of Health & Social Services or any other state's registry? If yes, give details on an attached sheet, including date and type of action.	☐	☐
2.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	☐	☐
3.	Have you ever surrendered, resigned, cancelled or been denied a professional license or other license in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	☐	☐
4.	Have you ever failed to pass any state board examination or NCLEX? If yes, give details on an attached sheet.	☐	☐
5.	Has any licensing agency ever taken any disciplinary action against you, including but not limited to, any reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the licensing agency and date of action.	☐	☐
6.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	☐	☐
7.	Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
8.	Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
9.	Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	☐	☐
10.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	☐	☐
11.	Are you registered, certified, or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	☐	☐
12.	Have you ever been registered, certified, or licensed under any other name(s)? If yes, state name(s) credentialed under.	☐	☐

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as a licensed practical nurse" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned nursing judgments and to learn and keep abreast of nursing developments; and
2. The ability to communicate those judgments and nursing information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform nursing tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
13	Do you have a medical condition which in any way impairs or limits your ability to practice nursing with reasonable skill and safety? If yes, please explain.	☐	☐
14.	Does your use of chemical substance(s) in any way impair or limit your ability to practice nursing with reasonable skill and safety? If yes, please explain.	☐	☐
15.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	☐	☐
16.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	☐	☐
17.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	☐	☐
18.	Are you currently engaged in the illegal use of controlled dangerous substances?	☐	☐
19.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	☐	☐

PLEASE READ AND SIGN BELOW

I, the above-named applicant, state that I am the person referred to in this application and that all the statements herein contained are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my license or other disciplinary action. I also understand that if I am issued a license, failure to comply with the laws or rules of either the Board of Nursing or the Department of Regulation and Licensing will be cause for disciplinary action.

Applicant Signature _____ Date _____

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name Middle Initial Last Name

_____

Profession

Date of Birth _____ _____ _____

month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.

[2] Sections 49.22, and 440.13, Wis. Stats.

[3] Section 440.12, Wis. Stats.

[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

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STATEMENT OF GRADUATION

("Board-approved school" U.S. or U.S. Territory)

APPLICANT: Complete the top portion of this form and forward to the school of nursing in which you received your basic nursing education. Request the school to return the completed form directly to the **Wisconsin Board of Nursing.**

CHECK ONE: ☐ Registered Nurse ☐ Licensed Practical Nurse

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

ADDRESS _____
(NO. & STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DATE OF BIRTH _____ _____ _____ SOCIAL SECURITY # _____
(MONTH) (DAY) (YEAR) Voluntary, for use by school to locate your records

NURSING EDUCATION PROGRAM COMPLETED _____
(NAME OF SCHOOL OF NURSING)

LOCATION _____ DATE OF GRADUATION _____ _____ _____
(CITY) (STATE) (COUNTRY) (MONTH) (DAY) (YEAR)

I HEREBY AUTHORIZE THE _____ SCHOOL OF NURSING TO FURNISH THE WISCONSIN BOARD OF NURSING THE INFORMATION REQUESTED BELOW.

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE - FOR SCHOOL OF NURSING

This is to certify that _____
(name)

successfully completed the nursing program at _____
(name of school of nursing)

_____ and graduated on _____ _____ _____
(location) (MONTH) (DAY) (YEAR)

The type of registered nursing completed was:
- ☐ BSN
- ☐ ADN
- ☐ BA
- ☐ DIP

The type of practical nursing completed was: ☐ LPN/TPN

Was this school of nursing state approved at the time of graduation? ☐ YES ☐ NO

SCHOOL SEAL/STAMP

Signed: _____

Title: _____

Date: _____

#259 (Rev. 02/02)
Ch. 441, Stats.

Wisconsin Department of Regulation & Licensing

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Website: http://www.drl.state.wi.us/

STATEMENT OF FOREIGN NURSING EDUCATION

(Foreign Graduates Only, Including Canada)

APPLICANT: Complete the top portion of this form and forward to the school of nursing in which you received your basic nursing education. Request the school to return the completed form directly to the **Wisconsin Board of Nursing**.

CHECK ONE: ☐ Registered Nurse ☐ Licensed Practical Nurse

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

ADDRESS _____
(NO. & STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DATE OF BIRTH _____ _____ _____
(MONTH) (DAY) (YEAR)

NURSING EDUCATION PROGRAM COMPLETED _____
(NAME OF SCHOOL OF NURSING)

LOCATION _____ DATE OF GRADUATION _____ _____ _____
(CITY) (STATE) (COUNTRY) (MONTH) (DAY) (YEAR)

I HEREBY AUTHORIZE THE _____ SCHOOL OF NURSING TO FURNISH THE WISCONSIN BOARD OF NURSING THE INFORMATION REQUESTED BELOW.

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE - FOR SCHOOL OF NURSING

TO: DIRECTOR, SCHOOL OF NURSING: Please complete this form and return it directly to the Board of Nursing, Department of Regulation & Licensing, P.O. Box 8935, Madison, WI 53708-8935.

Date of Graduation _____ _____ _____ Type of Diploma/Degree _____
(MONTH) (DAY) (YEAR)

Was the school **accredited** at the time this applicant graduated? ☐ Yes ☐ No

If yes, what was the name of the accrediting agency? _____

What was the **primary spoken and written language of instruction** used in the school when this applicant graduated? _____

SCHOOL SEAL/STAMP

Signed: _____

Title: _____

Date: _____

#1006 (Rev. 02/02)
Ch. 441, Stats.

Wisconsin Department of Regulation & Licensing

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Website: http://www.drl.state.wi.us/

REQUEST FOR TEMPORARY PERMIT FOR REGISTERED NURSE OR LICENSED PRACTICAL NURSE

CHECK ONE: ☐ Registered Nurse ☐ Licensed Practical Nurse

A completed application, with proof of graduation from a board-approved school of professional nursing and the fee specified, must be received in the board office prior to granting a temporary permit. Applicants who have not taken the NCLEX or, have taken the NCLEX and are awaiting results are required to practice under the **direct supervision** of a credentialed R.N. who has a current active registered nurse license in Wisconsin. Applicants who have a current license in another state or U.S. territory are not required to practice under direct supervision.

A temporary permit is valid for 90 days or until the holder is notified he/she failed the NCLEX. **Temporary permits are non-renewable.**

NAME OF APPLICANT: (Please print) _____

Please check one:

☐ I am currently licensed as an R.N./L.P.N. in another state or U. S. Territory and have no past or pending disciplinary actions in another state. ***(May practice without direct supervision of an R.N. Statement of Supervising R.N. is not required.)*** I will be practicing in the state of Wisconsin at:

Name of Facility _____ Street Address _____

City _____, WI Zip _____ Phone Number (_____) _____

Attach a copy of your current license from another state.

☐ I plan to take the NCLEX for R.N./L.P.N. and wish to begin practicing prior to taking the examination. ***(Direct supervision by an R.N. is required)***

☐ My initial application for licensure as an R.N./L.P.N. is pending in another state or U.S. territory. I have not failed any licensing examination in another state. I wish to begin practicing pending receipt of examination results and credentialing. ***(Direct supervision by an R.N. is required.)***

STATEMENT OF SUPERVISING REGISTERED NURSE

The above-named applicant will be employed to work as an R.N./L.P.N. at the address listed below. Direct supervision by an R.N. will be provided.

The duration of this temporary permit is for a period of 90 days or until the holder is notified he/she failed the NCLEX. **Temporary permits are non-renewable.**

_____
Supervisor Signature and Title

_____
Print Name and Wisconsin RN License Number

(_____) _____
Phone Number

_____
Facility Name

_____
Street Address

_____
City and State Zip Code

_____
Date

#2433 (Rev. 02/02)
Ch. 441, Stats.

Wisconsin Department of Regulation & Licensing

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Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

VERIFICATION OF LICENSURE

APPLICANT: Complete the top portion of this form and forward to the Board(s) in the state(s) in which you have ever been licensed. (This form may be copied.)

CHECK ONE: ☐ Registered Nurse ☐ Licensed Practical Nurse

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

ADDRESS _____
(NO. & STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DATE OF BIRTH _____ _____ _____ ORIGINAL LICENSE # _____
(MONTH) (DAY) (YEAR) DATE ISSUED (YEAR)

NAME OF SCHOOL OF NURSING (NO INITIALS) _____

LOCATION _____
(CITY) (STATE) (COUNTRY)

I HEREBY AUTHORIZE THE _____ BOARD OF NURSING TO FURNISH THE WISCONSIN BOARD OF NURSING THE INFORMATION REQUESTED BELOW.

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE

STATE BOARD: Please complete this section and submit it to the Wisconsin Board of Nursing at P.O. Box 8935, Madison, WI 53708.

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

Original License Number _____ Date of Issuance (Month/Day/Year) _____

Check one:
☐ RN
☐ LPN

Licensed By:
☐ Examination
☐ Endorsement
☐ Waiver

Was the examination in English?
☐ Yes ☐ No

Current Licensure Status:
☐ Active
☐ Inactive
☐ Lapsed

Has this license ever been encumbered (revoked, suspended, surrendered, restricted, limited, placed on probation, etc.) in any way?
☐ Yes ☐ No If yes, attach explanation and copy of the public documents.

SEAL

Signed: _____

Title: _____

State: _____ Date: _____

#741 (Rev. 9/02)
Ch. 441, Stats.

Wisconsin Department of Regulation & Licensing

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Madison, WI 53708-8935

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Madison, WI 53703

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Phone #: **(608) 266-2112**

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us/

CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a $6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: _____

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth	Social Security Number
_____ month _____ day _____ year	_____ Information helps us identify your record, but is voluntary. It is not available to the public.

Ethnic/gender information is required to check criminal information records.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: _____

2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

   It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

OFFENSE	DATE	CITY/STATE

Attach additional sheet(s) if necessary.

Wisconsin Department of Regulation & Licensing

	YES	NO	MO/YR COMPLETED
3. Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program?	☐	☐	_____
Did you successfully complete the program?	☐	☐	_____

Please attach the certificate of completion/discharge summary.

	(Check all that apply)	YES	NO	MO/YR COMPLETED
4. Have you ever been sentenced to:	☐ Probation	☐	☐	_____
	☐ Parole	☐	☐	_____
	☐ Ordered to pay restitution	☐	☐	_____
Did you successfully complete one of the above as ordered by the court?		☐	☐	_____

If you are currently on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are **pending**. Submit a copy of the police report/criminal complaint for each of the following pending charges.

PENDING CHARGE	DATE OF ARREST	LOCATION OF ARREST (city/state)

Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

_____

_____

_____

_____

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

_____ _____

Signature Date

Signed and sworn before me this _____ day of _____, 20 _____.

_____ _____

Signature of Notary Public Date

My commission (is permanent) _____ expires _____. **SEAL**

Department of Regulation & Licensing

State of Wisconsin
(608) 266-2112
TTY# (608) 267-2416 } hearing or speech
TRS# 1-800-947-3529 } impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 267-1803

NOTICES

TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.[a] An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

PROCEDURES ON APPLICATION DENIAL

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at *http://www.legis.state.wi.us/rsb/code/rl/rl.html* and may also be obtained from the department.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at *http://www.drl.state.wi.us/* under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

AMERICANS WITH DISABILITIES ACT

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Communications and examinations: Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 10/00) ss. 15.04 (1) (m), 19.35, Stats.

[a] Section RL 4.06 of the Wisconsin Administrative Code