

# Wisconsin Department of Safety and Professional Services

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Website: <http://dsps.wi.gov>

## BOARD OF NURSING

### APPLICATION FOR RE-REGISTRATION OF REGISTERED NURSE/LICENSED PRACTICAL NURSE LICENSE

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

- Your name and address are available to the public.  
 Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

PLEASE TYPE OR PRINT IN INK

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth ____ month ____ day ____ year	Daytime Telephone Number (____) _____ - _____
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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

Primary Residence: \_\_\_\_\_ (State)  
("state of primary residence" means the state of a person's declared fixed permanent and principal home for legal purposes, such as voting, driver's license, or paying taxes).

State of Original Licensure: \_\_\_\_\_

Wisconsin Original Licensure Number\*: \_\_\_\_\_

Date of Expiration\*: \_\_\_\_\_

\*To obtain your Wisconsin original license number and expiration date go to <http://dsps.wi.gov>.

- My license has been expired for more than 5 years and I am requesting a limited license for the purposes of completing the clinical portion of a nurse refresher course.

APPLICATION FEES (Make check payable to Department of Safety and Professional Services and attach to application.)

Check box for the type of license you are applying for:

RN \$ 82.00 Re-Registration Fee  
\$ 25.00 Late Renewal Fee  
\$ 107.00 Total fee attached

LPN \$ 82.00 Re-Registration Fee  
\$ 25.00 Late Renewal Fee  
\$ 107.00 Total fee attached

For Receiving Use Only

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

Fee(s) attached to this application (Form #2460)

Verification of Licensure (Form #741 or NURSYS) from all states where licensed since expiration of your Wisconsin license (includes active and inactive licenses)

Social Security Form (Page 5)

Copies of malpractice suit(s). Court documents with allegations and settlement (if applicable)

**IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.**

**PRACTICE:** Account for all activities and practice starting **from the date of expiration of Wisconsin license to the present time.** **Must include professional and non-professional activities. ALL activities must be accounted for.** No more than a 3-month time gap is allowed. Please include dates of unemployment. Example: stayed home to raise children, retail employment. (Attach additional sheets as necessary.)

EMPLOYER NAME	CAPACITY EMPLOYED <small>(i.e. office staff, food service, RN, LPN, etc.)</small>	LOCATION OF EMPLOYMENT <small>(List City &amp; State)</small>	DATES EMPLOYED <small>(Month/Year Format) From – To</small>

Note: If you have not had registered nurse employment within the last 5 years, you will be issued a limited license to obtain a refresher course.

**I AM OR HAVE BEEN LICENSED IN THE FOLLOWING STATES (UNLIMITED) FROM THE EXPIRATION DATE OF WI RN/LPN LICENSE:**

By Written Exam: \_\_\_\_\_

By Endorsement/Reciprocity: \_\_\_\_\_

\*To obtain verification from another state board, you **must first** view the NURSYS web site at ([www.nursys.com](http://www.nursys.com)) to see if your verification can be processed through NURSYS. Please follow their instructions for online processing.

If the state in which you **currently have or ever held** a license as a registered nurse/licensed practice nurse **is not** one of the participating states which uses the NURSYS program, complete Form #741 (this form may be copied). You must first contact each state board prior to forwarding this form to see if a fee is required for this service. The state(s) you are requesting verification from must return completed Form #741 directly to the Board of Nursing at P.O. Box 8935, Madison, WI 53708-8935. Verifications received from the applicant will be rejected by the Board.

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

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 1. Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? <b>If yes, give details on an attached sheet, including the name of the profession and the agency.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? <b>If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is disciplinary action pending against you in any jurisdiction? <b>If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |

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- |   | <u>YES</u>               | <u>NO</u>                |
|---|--------------------------|--------------------------|
| 5. Do you have any felony or misdemeanor charges pending against you? <b>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 <u>Driving While Intoxicated</u> (DWI) charges.)</b>       | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been convicted of a misdemeanor or a felony? <b>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 <u>Driving While Intoxicated</u> (DWI) charges.)</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you incarcerated, on probation or on parole for any conviction? <b>If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have any suits or claims ever been filed against you as a result of professional services? <b>If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you registered or licensed in any other profession(s)? <b>If yes, state what profession(s) and in what states(s).</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been credentialed under any other name(s)? <b>If yes, state name(s) credentialed under.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |

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

"Ability to practice as a registered nurse/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.

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 11. Do you have a medical condition which in any way impairs or limits your ability to practice nursing with reasonable skill and safety? <b>If yes, please explain.</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does your use of chemical substance(s) in any way impair or limit your ability to practice nursing with reasonable skill and safety? <b>If yes, please explain.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |

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- |   | <u>YES</u>               | <u>NO</u>                |
|---|--------------------------|--------------------------|
| 13. 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? <b>If yes, please explain.</b>                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. 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? <b>If yes, please explain.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? <b>If yes, please explain.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are you currently engaged in the illegal use of controlled dangerous substances?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. 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? <b>If yes, please explain.</b> | <input type="checkbox"/> | <input type="checkbox"/> |

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## CERTIFICATION OF LEGAL STATUS:

I declare under penalty of law that I am (check one):

- A citizen or national of the United States, or
- A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at <http://www.uscis.gov>.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

## CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

## AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

