

# Wisconsin Department of Safety and Professional Services

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

**Ship To:** 1400 E. Washington Avenue  
Madison, WI 53703  
**E-Mail:** [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
**Website:** <http://dsps.wi.gov>

## BOARD OF NURSING

### INFORMATION FOR REGISTERED NURSE/LICENSED PRACTICAL NURSE LICENSURE BY EXAMINATION

#### REQUIREMENTS FOR EXAMINATION CANDIDATES

An applicant is eligible for the examination for Registered Nurse (RN) or Licensed Practical Nurse (LPN) if the applicant has:

- (1) Graduated from or completed a WI Board-Approved School or comparable school of Professional/Practical Nursing Program.
- (2) Graduated from high school (two years are required for LPN) or its equivalent.
- (3) Does not have an arrest or conviction record, subject to the Fair Employment Act. **See Convictions and Pending Charges Form #2252.**

The NCLEX Examination is administered year-round via Computerized Adaptive Testing (CAT). Your eligibility for examination will be determined by the WI Board of Nursing upon receipt of a completed application (Form #739) and all supporting documents.

To be eligible to take the NCLEX prior to graduation or completion, please have your school submit WI Act 114 Certificate of Approval to take Examination (Form #3049) in addition to your application.

#### INSTRUCTIONS FOR COMPLETING THE APPLICATION

Mail all forms below to the following address:

DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES (DSPS)  
WI BOARD OF NURSING  
P.O. BOX 8935  
MADISON, WI 53708-8935

- 1. Application (Form #739):** Complete the application and attach the appropriate fee. When completing page one of this form, you must indicate what type of degree received or program completed on the space provided. List the graduation or completion of program date and indicate one of the following: BSN, ADN, BA, DIP, Pre-MSN Registered Nursing Program Requirements (Direct Entry), LPN/TPN, or other. If other is listed, please describe further. Make check payable to DSPS.
- 2. WI Board-Approved Statement of Graduation or Completion (DSPS Form #259): (For WI Board-approved School only)** Complete and forward to your Board-Approved School of Nursing. This form must be returned directly from your school to the WI Board of Nursing. 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 from or completed the Board-Approved School of Professional/Practical Nursing Program. Anticipated dates of graduation or completion of the Board-Approved School of Professional/Practical Nursing Program will not be accepted. If you are applying for RN licensure by examination through completion of the Pre-MSN basic nursing requirements, there is no guarantee that you will be eligible for a RN license in other states.
- 3. Official Transcripts: (For Non-WI Board-Approved School only)** This must be sent directly from your school to the WI Board of Nursing. Official transcripts received from the applicant will be rejected by the Board.

# Wisconsin Department of Safety and Professional Services

4. **CGFNS Certificate Required: (RN Foreign Graduates only)** Contact the Commission of Foreign Nursing Schools at 3600 Market St., Suite 400, Philadelphia, PA 19104-2651, or via (215) 349-8767, to request a valid certificate be sent directly to the WI Board of Nursing. Certificates received from the applicant will be rejected by the Board.

**Credential Evaluation Services (CES) Report Required: (LPN Foreign Graduates only)** Contact the Commission of Foreign Nursing Schools at 3600 Market St., Suite 400, Philadelphia, PA 19104-2651, or via (215) 349-8767, to request a valid CES report to be sent directly to the WI Board of Nursing. Reports received from the applicant will be rejected by the Board.

**TOEFL/IELTS Report Required: (LPN Foreign Graduates only)** Contact the Test of English as a Foreign Language at P.O. Box 6151, Princeton, NJ 08541-6151, or International English Language Testing System at [www.ielts.org](http://www.ielts.org), to request a copy of the test result scores be sent directly to the WI Board of Nursing. Certificates received from the applicant will be rejected by the Board.

5. **Temporary Permit (Form #2434): (Optional)** In addition to completing the RN/LPN Exam Application (Form #739), complete the initial exam applicant portion of Form #2434. Return this form to the Board office with your application, with the required fee, and the additional \$10.00 temporary permit fee. If more than one temporary permit is desired, submit an additional Form #2434 and \$10.00 permit fee for each supervising RN.

If you do not have a supervising RN at this time, you may submit Form #2434 when you have a supervising RN. An applicant for RN/LPN licensure who has graduated from or completed a board-approved school or comparable school of professional/practical nursing program, may be eligible for a temporary permit upon submission of a completed application, supporting documents, credential fee, exam fee, and temporary permit 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 valid for a period of three months or until the holder receives notification of failing the NCLEX examination.

An applicant for RN/LPN licensure who holds a valid permit under this Temporary Permit section or Wis. Admin. Code N 3.05(4)(a) may use the title “Graduate Nurse/Graduate Practical Nurse” or the letters “GN/GPN” 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 a RN. **The supervisor must be on-site and immediately available at all times.**

**You may not practice as a RN/LPN in Wisconsin unless you have either a permanent license or temporary permit.**

6. **NCLEX Registration:** To register for the NCLEX examination you must go online to <http://www.vue.com> and follow the NCLEX Registration Instructions.

## **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) 266-2112 or TTY at (608) 266-2416.

## **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) 266-2112 or TTY at (608) 267-2416.

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## BOARD OF NURSING

### REGISTERED NURSE/LICENSED PRACTICAL NURSE LICENSURE BY EXAMINATION APPLICATION

Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stat. § 440.12).

<b>PLEASE TYPE OR PRINT IN INK</b>				<input type="checkbox"/> 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).
Last Name	First Name	MI	Former / Maiden Name(s)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address (street, city, state, zip)			Daytime Telephone Number	
<input type="text"/>			<input type="text"/> - <input type="text"/> - <input type="text"/>	
Mailing Address (if different)			Date of Birth	
<input type="text"/>			<input type="text"/> / <input type="text"/> / <input type="text"/>	
Social Security #		Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.		
<input type="text"/>				
<i>Ethnicity/gender status information is optional.</i>				
<b>Ethnicity:</b> <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hispanic <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other				
<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F				
Email Address				
<input type="text"/>				
Have you ever been licensed in Wisconsin as a Registered Nurse/Licensed Practical Nurse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, do not complete this application. If your RN/LPN license has been expired for five or more years, you will need to submit a Re-Registration Application (DSPS Form #2460).				
<b>Nursing School:</b> <input type="text"/>			<b>What is your state of primary residence?</b>	
<b>School Address:</b>			<input type="text"/> "Primary state of residence" is defined as the state of a person's declared fixed permanent and principal home for legal purposes; domicile.	
(City) <input type="text"/> (State) <input type="text"/>			<b>If not Wisconsin, do you plan to move to Wisconsin and take up primary residence?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Graduation or Completion of Program Date:</b> <input type="text"/> / <input type="text"/> / <input type="text"/>				
<b>Type of Degree/Program:</b> <input type="text"/>				

**APPLICATION FEES:** Make check payable to DSPS and attach to application. Check box for the type of license for which you are applying.

<input type="checkbox"/> RN \$75.00 Initial License Fee	<input type="checkbox"/> LPN \$75.00 Initial License Fee
<input type="checkbox"/> \$15.00 Contract Exam Fee	<input type="checkbox"/> \$15.00 Contract Exam Fee
<b>\$90.00 Total Fee Attached</b>	<b>\$90.00 Total Fee Attached</b>

**CHECK BOX FOR TEMPORARY PERMIT** in addition to the above fee  
(This permit fee is non-refundable)

\$10.00

**For Receiving Use Only (30/31)**

# Wisconsin Department of Safety and Professional Services

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

- Fee(s) attached to this completed Application (Form #739)
- WI Board-Approved Statement of Graduation or Completion from Nursing School (Form #259) for WI Board-Approved Schools only. If you are applying for RN licensure by examination through completion of the Pre-MSN basic nursing requirements program, there is no guarantee that you will be eligible for a RN license in other states.
- Verification of Licensure (Form #741) includes all active and inactive licenses you have ever held in another state as a nurse. See below.\*
- Official Transcripts (for Non-WI Board-Approved School only) must be sent directly from your school to the Board of Nursing at P.O. Box 8935, Madison, WI 53708-8935. Official transcripts received from the applicant will be rejected by the Board.
- If applicable: Conviction and Pending Charges Form #2252 and copies of malpractice suit(s). Submit copy of court documents of criminal complaint and judgment of conviction.
- CGFNS certificate (RN Foreign Graduates only)
- CES Report with TOEFL/IELTS (LPN Foreign Graduates only)

**PRACTICE:** Account for all activities and practice starting from the date of graduation or the completion of the program to the present time. **Must include professional and non-professional activities. All dates and time must be accounted for. No more than a three-month gap allowed.** Please include dates unemployed. Example: stayed home to raise children, worked in retail, etc. (Attach additional sheets if necessary.)

EMPLOYER NAME	CAPACITY EMPLOYED <small>(i.e. office staff, food service, RN, LPN, etc.)</small>	LOCATION OF EMPLOYMENT <small>(City/State)</small>	DATES EMPLOYED <small>(Month/Year)</small>
		(City) <input style="width: 150px;" type="text"/> (State) <input style="width: 50px;" type="text"/>	(From) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> (To) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>
		(City) <input style="width: 150px;" type="text"/> (State) <input style="width: 50px;" type="text"/>	(From) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> (To) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>
		(City) <input style="width: 150px;" type="text"/> (State) <input style="width: 50px;" type="text"/>	(From) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> (To) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>
		(City) <input style="width: 150px;" type="text"/> (State) <input style="width: 50px;" type="text"/>	(From) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> (To) <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>

List state(s) you currently practice in:

**I AM, OR HAVE BEEN, LICENSED IN THE FOLLOWING STATE(S) (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 you must first view NURSYS at <https://www.nursys.com/> to see if your certification can be processed through NURSYS. Please follow their instructions for online processing. For verification of all licenses in other states, use Form #741.**

# Wisconsin Department of Safety and Professional Services

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

		<u>YES</u>	<u>NO</u>
1.	Are you familiar with the state health laws, rules, and regulations of the Wisconsin Department of Health regarding communicable diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license, or other license in Wisconsin or any other jurisdiction? <b>If yes, including the name of the profession and the agency.</b> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever failed to pass any state board examination, province of Canada examination, or NCLEX? <b>If yes, give details.</b> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has any licensing agency ever taken any disciplinary action against you, including but not limited to, any reprimand, suspension, probation, limitation, or revocation? <b>If yes, attach a sheet providing details about the action, including the name of the licensing agency and date of action.</b>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever been terminated from any employment related to nursing? <b>If yes, give related details on an attached sheet, including name of employer(s) and date(s) of employment.</b>	<input type="checkbox"/>	<input type="checkbox"/>
6.	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"/>
7.	Have you ever been convicted of a misdemeanor or a felony or do you have any felony or misdemeanor charges pending against you? <b>If yes, submit Convictions and Pending Charges (Form #2252).</b>	<input type="checkbox"/>	<input type="checkbox"/>
8.	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"/>
9.	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"/>
10.	Are you registered, certified, or licensed in any other profession(s)? <b>If yes, state what profession(s) and in what state(s).</b> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you ever been registered, certified, or licensed under any other name(s)? <b>If yes, state name(s) under which you were credentialed.</b> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<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.

# Wisconsin Department of Safety and Professional Services

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

		YES	NO
12.	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"/>
13.	Does your use of chemical substances 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"/>
14.	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"/>
15.	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"/>
16.	Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, or voyeurism? <b>If yes, please explain.</b>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/>	<input type="checkbox"/>
18.	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 on additional sheet.</b>	<input type="checkbox"/>	<input type="checkbox"/>

**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: \_\_\_\_\_