

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935

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Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@dps.wi.gov
Website: http://dps.wi.gov

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 OR COMPLETION _____
(CITY) (STATE) (COUNTRY) (MONTH) (DAY) (YEAR)

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

DATE _____ SIGNATURE OF APPLICANT _____

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 Safety and Professional Services, P.O. Box 8935, Madison, WI 53708-8935.

Date of Graduation or Completion _____ Type of Program _____
(MONTH) (DAY) (YEAR)

Was the school **accredited** at the time this applicant graduated from or completed the program?

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 from or completed the program? _____

SCHOOL SEAL/STAMP

Signed: _____

Title: _____

Date: _____