

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

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

BOARD OF NURSING

VERIFICATION OF LICENSURE

APPLICANT: Complete the top portion of this form and forward to Board of the state or territory in which you have ever held a credential.

Type: (check one) Advanced Practice Nurse Prescriber Registered Nurse Licensed Practical Nurse Nurse Midwife

Name:
(last) (first) (middle) (maiden/former)

Address:
(street /P.O. box , city, state) (zip code)

/ /
Date of Birth

Original license # of the state
you are requiring verification from

/ /
Date Issued

Full Name of Nursing School:

Location of Nursing School:
(city) (state) (country)

I hereby authorize the Board of Nursing to furnish the Wisconsin Board of
(list the state you are requesting verification from)
Nursing the information requested below.

Date: / / Signature: _____

APPLICANT DO NOT WRITE BELOW THIS LINE

STATE BOARD: Complete this section and submit to the Wisconsin Board of Nursing at the above address.

Name of Requestor:
(last) (first) (middle) (maiden/former)

Original License Number

/ /
Date of Issuance

Type: (check one)

- APN
 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 an explanation and a copy of the public documents.

Signature: _____

Title:

State: Date: / /

