

# Wisconsin Department of Safety and Professional Services

**Mail To:** P.O. Box 8935  
Madison, WI 53708-8935  
**Fax #:** (608) 251-3036  
**Phone #:** (608) 266-2112

**Office Location:** 4822 Madison Yards Way  
Madison, WI 53705  
**E-Mail:** [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
**Website:** <http://dsps.wi.gov>

## BOARD OF NURSING

### OUT OF STATE NURSE TEMPORARY CAMP PRACTICE NOTIFICATION FORM

Pursuant to Wis. Stat. § [441.115\(3\)\(a\)](#), you may practice professional nursing to provide treatment to campers and staff for not more than 90 days in any year without holding a license granted under Wis. Stat. ch. 441, [Subch. I](#) if all of the following apply:

1. The recreational or educational camp is licensed under Wis. Stat. § [97.67\(1\)](#),
2. You hold in good standing a non-multistate license, permit, registration, or certificate granted by another state or territory or by a Canadian province or territory that authorizes you to perform acts that are substantially the same as those performed by a person licensed as a registered nurse under Wis. Stat. ch. 441, [Subch. I](#),
3. The requirements for the license, permit, registration, or certificate that the person holds in Item 2 above are substantially equivalent to the requirements for Wisconsin single-state licensure as a registered nurse under Wis. Stat. ch. 441, [Subch. I](#),
4. You are not under active investigation by a licensing authority or law enforcement authority in any state, federal, or foreign jurisdiction, and
5. You submit this form to the Wisconsin Board of Nursing before practicing.

**IMPORTANT NOTE:** Wis. Stat. § [441.115\(3\)\(a\)](#) provisions do not apply to a person who holds a multistate license, as defined in Wis. Stat. § [441.51\(2\)\(h\)](#), issued by a party state, as defined in Wis. Stat. § [441.51\(2\)\(k\)](#).

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<b>PLEASE TYPE OR PRINT IN INK</b>		<input type="checkbox"/> Your name, address, phone number, and e-mail address are available to the public. Check box to withhold street address/PO Box, phone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).	
<b>Last Name</b> <input style="width: 100%;" type="text"/>		<b>First Name</b> <input style="width: 100%;" type="text"/>	<b>MI</b> <input style="width: 100%;" type="text"/>
<b>Date of Birth</b> (mm/dd/yyyy) <input style="width: 100%;" type="text"/>		<b>Daytime Telephone Number</b> <input style="width: 100%;" type="text"/> Ext. <input style="width: 100%;" type="text"/>	
<b>Address</b> (unit number and street) (city) (state, province, or territory) (zip or postal code) <input style="width: 100%;" type="text"/>		<b>Country</b> <input type="checkbox"/> U.S./territory <input type="checkbox"/> Canada/territory	
<b>Mailing Address</b> (if different) (unit number and street) (city) (state, province, or territory) (zip or postal code) <input style="width: 100%;" type="text"/>			
<b>E-mail Address</b> <input style="width: 100%;" type="text"/>			
<b>Social Security Number/Social Insurance Number</b> <input style="width: 100%;" type="text"/>		The Department may not disclose your Social Security Number or Social Insurance Number collected except as authorized by law.	
<b>Ethnicity/gender status information is optional.</b>			
<b>GENDER</b> <input type="checkbox"/> M <input type="checkbox"/> F		<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>CAMP INFORMATION</b>			
<b>Camp Name</b> <input style="width: 100%;" type="text"/>		<b>Full Name of Camp Contact</b> <input style="width: 100%;" type="text"/>	
<b>Camp Address</b> (street) (city) (state) (zip code) <input style="width: 100%;" type="text"/>			
<b>Camp Contact E-mail Address</b> <input style="width: 100%;" type="text"/>		<b>Camp Contact Phone Number</b> <input style="width: 100%;" type="text"/> Ext. <input style="width: 100%;" type="text"/>	
<b>List Dates of Practice</b> (Cannot exceed 90 days in any year.) <input style="width: 100%;" type="text"/>			

**Answer the following:** (Attach additional sheets if necessary.)

1.	I attest that the camp listed above is a recreational or educational camp licensed under Wis. Stat. § <a href="#">97.67(1)</a> . <b>If no, you do not meet requirements to practice in a camp setting under Wis. Stat. § <a href="#">441.115(3)(a)</a>.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No																
2.	Have you ever been credentialed in Wisconsin? <b>If yes, list your credential number</b> _____.	<input type="checkbox"/> Yes <input type="checkbox"/> No																
3.	I attest that I hold in good standing a <u>non-multistate</u> license, permit, registration, or certificate granted by another state or territory or by a Canadian province or territory <b>If yes, list all that apply.</b> (Attach additional sheets if necessary.)	<input type="checkbox"/> Yes <input type="checkbox"/> No																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">License Type</th> <th style="width: 25%;">Jurisdiction</th> <th style="width: 25%;">Credential Number</th> <th style="width: 25%;">Expiration Date (mm/dd/yyyy)</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td><input style="width: 100%;" type="text"/></td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td><input style="width: 100%;" type="text"/></td> </tr> </tbody> </table>			License Type	Jurisdiction	Credential Number	Expiration Date (mm/dd/yyyy)				<input style="width: 100%;" type="text"/>				<input style="width: 100%;" type="text"/>				<input style="width: 100%;" type="text"/>
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<b>If no, you do not meet requirements to practice in a camp setting under Wis. Stat. § <a href="#">441.115(3)(a)</a>.</b>																		

# Wisconsin Department of Safety and Professional Services

4.	Of the <b>credentials listed in Question 3</b> , I attest that the jurisdiction(s) I list below: <ul style="list-style-type: none"> <li>a. Authorize me to perform acts that are substantially the same as those performed by a person licensed as a registered nurse under Wis. Stat. ch. 441, <a href="#">Subch. I</a>, and</li> <li>b. Have license requirements that are substantially equivalent to the requirements for Wisconsin single-state licensure as a registered nurse in Wis. Stat. ch. 441, <a href="#">Subch. I</a>:</li> </ul> <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div> <b>If no, you do not meet requirements to practice in a camp setting under Wis. Stat. § <a href="#">441.115(3)(a)</a>.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	I attest that I am <u>not</u> under active investigation by a licensing authority or law enforcement authority in any state, federal, or foreign jurisdiction. <b>If no, you do not meet requirements to practice in a camp setting under Wis. Stat. § <a href="#">441.115(3)(a)</a>.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	I understand that under Wis. Stat. § <a href="#">441.115(3)(a)</a> , camp practice may <u>not</u> exceed 90 days in any year.	<input type="checkbox"/> Yes <input type="checkbox"/> No

**CONTINUING DUTY OF DISCLOSURE**

I understand that I have a continuing duty of disclosure. If information I have provided on this form becomes invalid, incorrect, or outdated, I understand that I am obliged to provide any necessary information to ensure the information on this form remains current, valid, and truthful. I understand that the Wisconsin Board of Nursing may view acts of omission as dishonesty.

**AFFIDAVIT**

I declare that I am the person referred to on this form 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 submission of this form may result in Wisconsin Board of Nursing action or penalties as may be provided by law.

By signing below, I am attesting that I have read the above statements (Continuing Duty of Disclosure and Affidavit) and understand the obligation I have should information I have provided to the Department of Safety and Professional Services change.

**Print full name:**

**Signature:**       **Date:**  /  /

(If unable to provide a digital signature, please print and sign form.)