Wisconsin Department of Safety and Professional Services

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BOARD OF NURSING

CERTIFICATION FORM FOR ADVANCED PRACTICE NURSE PRESCRIBERS

(Check all that apply)

☐ I am/will be an Advanced Practice Nurse Prescriber who practices as the employee of a healthcare provider and I am covered by a group liability policy providing individual coverage in the amounts set forth in Wis. Stat. § 655.23(4). I certify that I will prescribe only within the limits of the policy's coverage or shall obtain personal liability coverage for independent prescribing outside the scope of the group liability policy or policies.

☐ I am/will be an Advanced Practice Nurse Prescriber who practices as the employee of a healthcare provider, and I am covered by a group liability policy providing shared coverage. I certify that I will prescribe only under the supervision of, and as delegated by, a Physician or Certified Registered Nurse Anesthetist and consistent with the requirements for delegated acts established by Wis. Admin. Code N 6.03(2) and (3), or shall obtain personal liability coverage for independent prescribing outside of my employment setting.

☐ I am/will be an Advanced Practice Nurse Prescriber who practices as the employee of this state or a governmental subdivision, as defined under Wis. Stat. § 180.0103. I certify that I will prescribe only within the established scope of my employment, or shall obtain personal liability coverage for independent prescribing outside of my government employment setting.

☐ I am an Advanced Practice Nurse Prescriber who has personal liability coverage in the amounts of at least $1,000,000/$3,000,000.

Applicant Name: _____
(First Name, MI, Last Name)

Applicant Signature: _____ Date __ __ / __ __ / __ __ __ __
(Print and Sign Form)