Wisconsin Department of Safety and Professional Services

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BOARD OF NURSING

CERTIFICATION FORM FOR MALPRACTICE INSURANCE COVERAGE FOR NURSE-MIDWIFE

APPLICANT: Complete this section and check the appropriate box(s) by signing and dating this form to certify which of the following applies to you. Upload this form into your LicensE application, https://license.wi.gov/.

Last Name | **First Name** | **MI** | **Former / Maiden Name(s)**

Address (number, street, city, zip code) | **Application ID #** (if applicable)

Please check one of the following boxes:

☐ I hereby certify that I have malpractice liability insurance coverage in the amount specified in s. 655.23(4), Stats.

☐ I am not required to have malpractice insurance coverage because: (check one)

- ☐ I am a federal, state, county, city, village, or town employee who practices nurse-midwifery within the scope of my employment.
- ☐ I am an employee of the federal public health service under 42 U.S.C. s. 233(g).
- ☐ My employer has in effect malpractice liability insurance that provides coverage for me in the amount that is at least the minimum amount specified in Wis. Stat. § 655.23(4).
- ☐ I do not provide care for patients at this time, but I understand I must have malpractice liability insurance coverage in the amount specified in Wis. Stat. § 655.23(4) prior to beginning patient care.

Applicant Signature (If unable to provide a digital signature print and sign form.) | **Date** ☐☐ / ☐☐ / ☐☐☐☐

Upload this form directly into your LicensE application, https://license.wi.gov/.