

# 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

### CERTIFICATION OF MASTER'S OR DOCTORAL DEGREE

**APPLICANT:** Complete this section and submit to the college or university at which you received your master's or doctoral degree for completion. Form must be returned directly from the school to the Department.

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Former / Maiden Name(s)</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Address (number/street)</b>	<b>(city)</b>	<b>(state)</b>	<b>(zip code)</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>Date of Birth</b>	<b>Social Security Number</b> (voluntary-for use by school to locate your records)	<b>Date of Graduation</b> (Anticipated dates of graduation will not be accepted.)
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Application Number**

**ATTESTATION OF APPLICANT:** I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------

**Applicant Signature**

**Date**

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

**SCHOOL:** Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party\* Upload Portal at [license.wi.gov](http://license.wi.gov). You will need the application number shown above. (\*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DPS individual or entity submitting required documentation in support of a credential application.)

**Name of School**

**Location of School (City, State)**

**Date of Graduation or Completion**    (Anticipated dates of graduation will not be accepted.)

**Was Master's/Doctoral Degree in Nursing?**  Yes  No

**Title of Degree Granted**

**Was this College/University Regionally Accredited at the Time of Graduation?**  Yes  No

*Continued on next page.*

# Wisconsin Department of Safety and Professional Services

**ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT:** I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

 /  / 

**Signature of Dean or Department Head**

**Date**

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

 -  -  Ext \_\_\_\_\_

**Printed Name**

**Phone**

**Title**