WISCONSIN NURSE AIDE FORM 9110WI

NURSE AIDE REGISTRY OUT-OF-STATE APPLICATION

This application must be completed by persons who want to be entered on the Wisconsin Nurse Aide Registry (WNAR) through the Wisconsin Out-of-State application process. Please refer to the Reciprocity/Out-of-State Transfer section of the Wisconsin Candidate Handbook to determine your eligibility.

The personal information will only be used to determine whether you can be employed as a nurse aide and to notify employers of your eligibility status. Failure to provide complete and accurate information on your application may delay or prevent your entry on the Wisconsin Nurse Aide Registry.

APPLICANT MAILING INSTRUCTIONS

All applicants must complete Part I of this application and mail this application with the required documents by following instructions below depending on which state you are transferring from.

Individuals transferring from California, Colorado, District of Columba, Florida, Louisiana, Mississippi, Missouri, North Carolina or Pennsylvania should **mail** their completed Out-of-State application, the certificate/diploma from a basic nurse aide course, to include the date of completion, or a transcript or letter (must be on letterhead) from the training program verifying the number of hours of nurse aide training received to:

Wisconsin Department of Health Services
Office of Caregiver Quality
PO Box 2969
Madison, WI 53701

Individuals transferring from all other states (*not listed above*) **must mail** their completed applications to the state they received their initial basic nurse aide training from. They will complete PART II and send to WI DHS.

Please note, **faxed or emailed versions of the application will not be accepted.**

A complete list of State Nurse Aide Registries is available at: ncsbn.org/Directory_of_Nurse_Aide_Registries.pdf.

PART I

A. REGISTRY INFORMATION

1. Have you ever been listed on the Wisconsin Nurse Aide Registry? ☐Yes ☐No
2. In what state did you complete your nurse aide training? |__|__|
3. In what state were you first listed on the nurse aide registry? |__|__|
4. In what state are you currently listed on the nurse aide registry? |__|__|
   a. Include REGISTRY # (if applicable) |__|__|__|__|__|__|__|__|__|__|__|__|
5. List all other states where you have been listed on the Nurse Aide Registry:

|__|__| |__|__| |__|__| |__|__| |__|__|

B. PERSONAL INFORMATION

1. Social Security Number: |__|__|__|-|__| |__|-|__|__|__|__|

2. Gender: ☐Female ☐Male

3. Date of Birth: |__|__|-|__|__|-|__|__|__|__|
MONTH DAY YEAR

4. Current Legal Name: (Do not use Nicknames)

|__|__|__|__|__|__|__|__|__|__|__|__| |__|__|__|__|__|__|__|__|__|__| |__|
LAST FIRST MI

5. Previous Name: *(If applicable. Send proof of name change)*

|__|__|__|__|__|__|__|__|__|__|__|__| |__|__|__|__|__|__|__|__|__|__| |__|
LAST FIRST MI

6. Current Mailing Address:

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
STREET (number and name) APARTMENT NUMBER PO BOX

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| |__|__| | __|__|__|__|__|
CITY STATE ZIPCODE

7. Home Phone Number: |__|__|__|-|__|__|__|-|__|__|__|__|
Area Code

Work Phone Number: |__|__|__|-|__|__|__|-|__|__|__|__|
Area Code

8. E-Mail Address: (Required)

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

9. Do you have a SUBSTANTIATED FINDING OF CLIENT ABUSE, NEGLECT OR MISAPPROPRIATION OF CLIENT'S PROPERTY listed on a nurse aide registry in any other state?

☐No ☐Yes - name of state |__|__|

C. NURSE AIDE TRAINING PROGRAM INFORMATION

A nurse aide must have completed, at a minimum, a 75-hour basic nurse aide course. I have attached a copy of:

☐the certificate/diploma I received for completing the basic nurse aide course, or

☐a transcript that verifies I completed the basic nurse aide course.

Note: Your application will not be processed without a copy of your certificate/diploma or transcript.

D. APPLICANT SIGNATURE

I certify that all the information provided on this application is true and complete. I give my permission to any state registry to disclose all information requested on this application to Wisconsin Department of Health Services.

____

Signature of Applicant Date

Send this completed, signed application with all supporting documentation per APPLICANT MAILING INSTRUCTIONS above.

PART II – REGISTRY PERSONNEL COMPLETE PART II OF THIS FORM

Registry personnel — after you have completed Part II, please mail this application to:

Wisconsin Department of Health Services
Office of Caregiver Quality
PO Box 2969
Madison, WI 53701

A. Is the APPLICANT named in PART I listed on your Registry? ☐Yes ☐No

IF YES, Indicate Expiration Date: |__|__|-|__|__|-|__|__|__|__| AND State: |__|__|

MONTH DAY YEAR

The applicant named in **PART I** has met all state and federal requirements for LONG-TERM CARE.

☐Yes ☐No

The applicant named in **PART I** has met all state and federal requirements for HOME HEALTH CARE.

☐Yes ☐No

Is this registration current and in good standing?

☐Yes ☐No

B. The APPLICANT named in PART I was listed on the Registry based on the following ***(check all that apply)***:

☐a. Completed a STATE-APPROVED TRAINING PROGRAM: State |__|__| # of Hours: |__|__|__|

Name of Program

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

☐b. Passed a State-Approved Competency Evaluation after completion of training program:

Date: |__|__|-|__|__|-|__|__|__|__|
MONTH DAY YEAR

This training meets all current OBRA (Long Term Care Requirements): ☐Yes ☐No

This training meets all current Federal home health aide requirements: ☐Yes ☐No

☐c. Challenged a STATE-APPROVED COMPETENCY EVALUATION without completion of a training program.

☐d. "GRANDPARENTED" onto the Registry based on work experience as a nurse aide.

☐e. "DEEMED" onto the Registry based on completion of a training program deemed to meet OBRA long-term care requirements.

☐f. Based on reciprocity from the state of |__|__|.

C. **The Registry for this state has substantiated a finding of abuse, neglect, or misappropriation for the applicant.**

If "Yes," please attach a summary: ☐Yes ☐No

Completion of this form certifies that the information contained on the form relates to the applicant named in PART I and the information is on file in the office of the undersigned.

1. **Print name of official completing this application:**

   _____

2. **Signature:** _____

3. **Title:** _____

4. **Telephone Number:** _____

5. **Agency:** _____ **State:** _____ **Date:** _____