



Wisconsin Nurse Aide Registry – Out of State Application

Please follow directions carefully. Incomplete forms will be returned and will delay or prevent your transfer to the Wisconsin Nurse Aide Registry (WNAR). Please refer to the Reciprocity/Out-of-State Transfer section of the [Wisconsin Nurse Aide Candidate Handbook](#) to determine your eligibility.

Nurse Aide Applicant:

1. Complete all items in Section A. Please print legibly.
2. Sign at the bottom of Section A to verify the information is true and correct.
3. Attach a copy of your nurse aide training documentation that includes the date of completion and number of hours of nurse aide training. Please note, your application will **not** be processed without a copy of your training program's certificate/diploma or transcript/letter (must be on letterhead).
4. Mail this application with the required documents.
 - a. If you are transferring from **Arizona, California, Colorado, District of Columbia, Florida, Illinois, Louisiana, Mississippi, Missouri, North Carolina, North Dakota, Pennsylvania, or Tennessee** mail this form directly to the Wisconsin Registry.

**Wisconsin Department of Health Services
Division of Quality Assurance
Attn: Nurse Aide Training Consultant
PO Box 2969
Madison, WI 53701**
 - b. Individuals transferring from **all other states** (not listed above) must mail their completed application to the state they received their initial basic nurse aide training from. Other state Registry personnel will complete Section B and send to DHS.

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

Once your application has been processed by the Wisconsin Department of Health Services (DHS), you will receive a text or email notification indicating that a TMU © account has been created for you. Individuals can check to see if their name has been added to the Wisconsin Nurse Aide Registry at wi.tmuniverse.com. **Some individuals transferring from other states may be required to successfully complete a competency evaluation examination prior to being added to the WNAR.** If you are required to test, DHS will mail a letter to the address in your application which outlines this in further detail. You will have one (1) year from the date of the letter to pass the exam.

State Registry Personnel:

1. Please do not remove attached documents.
2. Complete Section B - Check or complete all items that apply.
3. Affix official agency stamp or seal.
4. Have authorized person sign and date the bottom.
5. Mail this request to the Wisconsin Nurse Aide Registry.

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Madison, WI 53701**

Out of State Application for the Wisconsin Nurse Aide Registry

Form 9110WI

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 may delay or prevent your entry on the Wisconsin Nurse Aide Registry.

Section A – Applicant Information (nurse aide completes this section)

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| Instructions | <ol style="list-style-type: none"> 1. Complete Section A (please print legibly). 2. Sign at the bottom to verify the information is true and correct. 3. Attach a copy of nurse aide (NA) training documentation that includes date of completion and number of hours of training. 4. Mail this application with the required documents. <ul style="list-style-type: none"> • If you are transferring from AZ, CA, CO, DC, FL, IL, LA, MS, MO, NC, ND, PA, or TN mail this form directly to the Wisconsin Registry. • Individuals transferring from all other states (not listed above) must mail their completed application to the state they received their initial basic nurse aide training from. Other state Registry personnel will complete Section B and send to WI DHS. |
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Personal	Legal Name Last First MI		Previous Name (if applicable – include proof of name change)			
	Social Security Number (Required)		<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (mm/dd/yyyy)	Telephone Number (including area code)	
	Current Mailing Address		Apartment #	City	State	Zip
	Email Address (Required)		Do you have a substantiated finding of abuse, neglect or misappropriation of client's property on another Registry? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what state(s)?						

NA Training/Registry	NA Training Documentation Included <input type="checkbox"/> Certificate/Diploma <input type="checkbox"/> Transcript/Letter		<i>Your application will not be processed without a copy of your training program's certificate/diploma or official transcript/letter</i>		NA Training State	NA Training Completion Date (mm/dd/yyyy)
	Have you ever been listed on Wisconsin's Nurse Aide Registry? <input type="checkbox"/> Yes <input type="checkbox"/> No Registry # (if applicable)			What state were you first listed on the Nurse Aide Registry?		
	What state are you currently listed on the Nurse Aide Registry?			List other states where you have been listed on the Nurse Aide Registry.		

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	Today's Date

Applicant → Send this completed, signed application with all supporting documentation per instructions above.

Section B – State Nurse Aide Registry Information (Registry Personnel complete this section)

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| Instructions:
<ol style="list-style-type: none"> 1. Please do not remove attached documents. 2. Check or complete all items that apply | <ol style="list-style-type: none"> 3. Affix official agency stamp or seal. 4. Have authorized person sign and date the bottom 5. Mail this application request to the Wisconsin Nurse Aide Registry |
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Is the applicant named in Section A listed on your Nurse Aide Registry? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, indicate registration number and expiration date (mm/dd/yyyy)	
Is this registration current and in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> Completed a state-approved training program: <ul style="list-style-type: none"> • Met all current OBRA (long-term care) requirements <input type="checkbox"/> Yes <input type="checkbox"/> No • Met all current Federal home health aide requirements <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Challenged (did not complete state-approved training program)		Training program name	
State	Training Completion Date (mm/dd/yyyy)	# of Training Hours	

Competency Evaluation Date (mm/dd/yyyy)

The method of registration was:
 Examination Deemed Grandfathered Reciprocity from: _____ (Please identify state)

The Registry for this state has substantiated a finding of abuse, neglect, or misappropriation of client's property for the applicant.
 Yes No If Yes, please attach a summary

Print name of official completing this application		Title	
Agency		State	Telephone Number
Signature		Date	

<i>After completion and signature, please mail this application to:</i> Wisconsin Department of Health Services Division of Quality Assurance Attn: Nurse Aide Training Consultant PO Box 2969 Madison, WI 53701	Affix state stamp or seal here
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