If you are a nurse aide candidate from another state who has completed a training program of 120 hours that included 32 hours of clinical, and

• You have successfully passed a nurse aide competency exam that is the same or substantially similar to the Wisconsin competency examination, you will receive a WI nurse aide certificate in the mail, or

• You have not successfully completed a nurse aide competency exam that is the same or substantially similar to the Wisconsin competency examination, you will be required to successfully complete the Wisconsin competency examination. You will receive an authorization letter along with a Competency Evaluation Application which will allow you to schedule testing for the Wisconsin competency examination.

If you are a nurse aide candidate from another state and have completed a training program less than 120 hours, you will receive Employment Verification forms to be completed by your employer(s). The completed, notarized forms must be returned in order to proceed with your application. If your employer(s) verify a minimum of 2088 hours of employment as a nurse aide during the previous 24 month period, and

• You have successfully passed a nurse aide competency exam that is the same or substantially similar to the Wisconsin competency examination, you will receive a WI nurse aide certificate in the mail, or

• You have not successfully completed a nurse aide competency exam that is the same or substantially similar to the Wisconsin examination, you will be required to successfully complete the Wisconsin competency examination. You will receive an authorization letter along with a Competency Evaluation Application which will allow you to schedule testing for the Wisconsin competency examination.

If you are a nurse aide candidate who has completed a training program less than 120 hours, and have less than 2088 hours of employment as a nurse aide in the previous 24 months, your application will be denied.

The Wisconsin Department of Health Services, Office of Caregiver Quality will process your application within 10 business days of our receipt. If you are eligible for placement on the Wisconsin Nurse Aide Registry, you will receive a WI Nurse Aide Registry Card within three (3) weeks.

To verify if your name has been added to the Wisconsin Nurse Aide Registry, you can search the nurse aide registry at: http://www.pearsonvue.com/wi/nurseaides/.

If you do not receive a WI Nurse Aide Registry Card within the three (3) weeks, call Pearson VUE at 1-877-329-8760.

If you have questions regarding your Out-of-State registry application, please contact the Wisconsin Department of Health Services, Office of Caregiver Quality at 608-261-8319.

Individuals transferring from California, Colorado, District of Columbia, Mississippi, Missouri, North Carolina, Pennsylvania, and South Carolina should send their application to:

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

We will NOT accept faxed versions of the application.

Individuals transferring from all other states must mail their completed application to the state where they are currently registered as a nurse aide. A complete list of State Nurse Aide Registries is available on Pearson VUE’s website at: www.pearsonvue.com/wi/nurseaides.

Failure to follow the correct mailing procedures will result in delayed processing of your application.
This application must be completed by persons who want to be entered on the Wisconsin Nurse Aide Registry through the Wisconsin Out-of-State process.

The personal information will only be used to determine whether you can be employed as an 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.

**PART I – APPLICANTS COMPLETE THIS SECTION (Please type or print neatly in black ink)**

**APPLICANT MAILING INSTRUCTIONS**

After you complete PART I, mail this application with the required documentation to the state where you are currently registered or trained as a nurse aide. SEE LIST OF NURSE AIDE STATE REGISTRIES ON PEARSON VUE'S WEB SITE AT WWW.PEARSONVUE.COM/WI/NURSEAIDES.

**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? 

5. List all other the 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 Date:  ______-____-____-

4. CURRENT Legal Name: DO NOT USE NICKNAMES

5. PREVIOUS Name: (if applicable)

6. CURRENT Mailing Address:

7. Home Phone Number:  ______-____-____-

8. Have you ever been CONVICTED of abuse or neglect of a person in your care, theft from a person in your care, or child abuse or neglect?    [ ] No    [ ] Yes

   If Yes, of what were you convicted? Check box(es) that apply:

   [ ] Abuse of a person in your care    [ ] Theft from a person in your care    [ ] Child neglect

   [ ] Neglect of a person in your care    [ ] Child abuse

   State where you were convicted:  ______

   Date(s) of conviction:  ______-____-____-

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  ______

Application continues on reverse side.
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.

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
☐ CHECK HERE IF YOU DO NOT WISH TO DISCLOSE YOUR NAME AND ADDRESS ON LISTS THAT ARE FURNISHED BY PEARSON VUE UPON REQUEST.

PLEASE READ THE MAILING INSTRUCTIONS BELOW CAREFULLY

1. If you are currently registered in CA, CO, DC, MS, MO, NC, PA, or SC, mail this form and your certificate of training completion to: Wisconsin Department of Health Services, Office of Caregiver Quality, PO Box 2969, Madison, WI 53701.
   We will NOT accept faxed versions of the application.

2. For all states not listed above in number 1, mail this form to the state where you are currently registered as a nurse aide.
   A complete list of State Nurse Aide Registries is available at www.pearsonvue.com/wi/nurseaides.

PART II — REGISTRY PERSONNEL COMPLETE PART II OF THIS FORM
Registry personnel — after you have completed Part II, 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 is listed on your Registry?  ☐ Yes  ☐ No
   IF YES—Indicate Expiration Date:  ______-______-______ AND State: ______

   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 1 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: ____________________________________________________________
       Date: ______-______-______
       This training meets all current OBRA (Long Term Care Requirements):  ☐ Yes  ☐ No
       This training meets all current Federal home health aide requirements:  ☐ Yes  ☐ No

   ☐ b. Passed a STATE-APPROVED COMPETENCY EVALUATION after completion of the training program:
       Date: ______-______-______

   ☐ 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: ___________________________________________  Title: ___________________________________________________

3. Telephone Number: __________________________________________

4. Agency: ___________________________________________________  State: ________________  Date: ________________