Wisconsin Nurse Aide Registry Renewal Form

Instructions

Federal and state regulations require that you performed nursing or nursing-related services for pay, under the supervision of a RN or LPN, during and since your last 24-month certification period.

Only use this form if your employer is not listed as an eligible employer in your TMU account.

- **Section I – Nurse aide information:** The nurse aide must complete this section of the form. Next, complete Section II or Section III.
- **Section II – Employer information (Facility/Provider):** The actual designated representative of the facility/provider where work was performed must complete this section of the form.
- **Section III – Renewal via out of state reciprocity:** Renew your Wisconsin certification via active, out of state registry status.
- **Return the completed forms via fax or email to: 608-226-5524 or dhswidqa_natcep@dhs.wisconsin.gov.**

Contact information

If you need assistance, call 608-261-9315 or email dhswidqa_natcep@dhs.wisconsin.gov.

Section I – Nurse aide information

The nurse aide must complete this section of the form.

Last name: _____ First name: _____ M.I.: _____

Last four SSN digits: _____ WI CNA number: _____

Previously used last names (if applicable): _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone number: _____ Email: _____

Attestation

I attest, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000, or imprisonment not to exceed six years or both (Wis. Stat. § 946.32).

Nurse aide signature: _____ Date: _____

Section II – Employer information (Facility/Provider)

The actual designated representative of the facility/provider where work was performed must complete this section of the form.

Facility or provider name: _____

Employer phone number: _____

Supervising nurse name: _____ Nurse license number: _____

Employer address: _____

City: _____ State: _____ ZIP code: _____

Employer type:_____

Employer email: _____

I certify that the nurse aide named above is/was employed by this facility as a nurse aide and performed nurse aide services for monetary compensation under the supervision of an RN or LPN during the time period from:

Date (*mm/dd/yyyy*): _____ to Date (*mm/dd/yyyy*): _____

The total hours this person was employed as a CNA during this period are _____ hours.

Attestation

I attest, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000, or imprisonment not to exceed six years or both (Wis. Stat. § 946.32).

Facility or provider information

Provider or facility representative name: _____

Provider or facility representative title: _____ Date: _____

Provider or facility representative signature: _____

Section III – Renew your Wisconsin nurse aide certification via out of state reciprocity (active status on another state's nurse aide registry). List states where you hold active nurse aide registry status and include the registry number.

State	Certification number	Lapse date

Return the completed forms via fax or email to: 608-226-5524 or dhswidqa_natcep@dhs.wisconsin.gov.

For more information about maintaining or renewing your Wisconsin nurse aide certification visit Nurse Aide Program: Training and Registry | Wisconsin Department of Health Services).