

STUDENT NURSE / GRADUATE NURSE TRAINING VERIFICATION

- Prior to issuing approval to take the State of Wisconsin nurse aide competency examination, the Department of Health Services reviews the training of all student nurses and graduate nurses who have not yet taken the National Council Licensure Examination (NCLEX). Completion of this form is mandatory, as the information collected on this form is used to determine if federal and state nurse aide training program requirements have been met by the nurse candidate.
- To be eligible as a student nurse, you must complete the courses that satisfy all nurse aide training requirements and complete 32 hours of hands-on clinical experience.
- **Approvals are valid for one year from the date of the original approval letter.**

DIRECTIONS

- Complete "Part I. Personal Information."
- Nursing instructor completes and signs "Part II. Education."
- Attach a copy of your transcript to this completed form.
- Submit these documents for verification and approval to: **DQA / Office of Caregiver Quality
 ATTN: Nurse Aide Training Consultant
 PO Box 2969
 Madison, WI 53701-2969**

| I. PERSONAL INFORMATION <i>(Applicant completes.)</i> | | | |
|---|------|---------------------|----------|
| Name | | Social Security No. | |
| Address | City | State | Zip Code |
| Email Address | | Telephone No. | |

| II. EDUCATION <i>(Nursing Instructor must complete and sign.)</i> | | | |
|---|--|---------------------------|--|
| <i>Your nursing instructor must indicate the specific, completed course number for the courses in which the following criteria were taught and in which the minimum of 32 hours of "hands on" clinical experience was obtained.</i> | | | |
| Aging Process: | | Clinical Course: | |
| Basic Nursing Skills: | | Communication Skills: | |
| Basic Restorative Skills: | | Death/Dying: | |
| Care of Cognitively Impaired: | | Infection Control: | |
| Name – Clinical Facility | | Type of Clinical Facility | |

| | | |
|--|---|---------------------------------|
| SIGNATURE – Nursing Instructor ➤ | Name – Nursing Instructor <i>(Print or type.)</i> | Date Signed <i>(MM/dd/yyyy)</i> |
|--|---|---------------------------------|

| DHS USE ONLY | | |
|--|-------|--------------------------|
| <input type="checkbox"/> Approved <input type="checkbox"/> Approval Pending – Information Needed: _____ <input type="checkbox"/> Denied – Reason for Denial: _____ | | |
| Name – Reviewer | Title | Date <i>(MM/dd/yyyy)</i> |