

Wisconsin Department of Safety and Professional Services

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BOARD OF NURSING

CERTIFICATION FORM FOR MALPRACTICE INSURANCE COVERAGE FOR NURSE-MIDWIFE

APPLICANT: Complete this section and check the appropriate box(s) by signing and dating this form to certify which of the following applies to you. Upload this form into your LicensE application, <https://license.wi.gov/>.

Last Name	First Name	MI	Former / Maiden Name(s)

Address (number, street, city, zip code)	Application ID # (if applicable)

Please check one of the following boxes:

- ☐ I hereby certify that I have malpractice liability insurance coverage in the amount specified in s. 655.23(4), Stats.
- ☐ I am not required to have malpractice insurance coverage because: (check one)
- ☐ I am a federal, state, county, city, village, or town employee who practices nurse-midwifery within the scope of my employment.
 - ☐ I am an employee of the federal public health service under 42 U.S.C. s. 233(g).
 - ☐ My employer has in effect malpractice liability insurance that provides coverage for me in the amount that is at least the minimum amount specified in Wis. Stat. § [655.23\(4\)](#).
 - ☐ I do not provide care for patients at this time, but I understand I must have malpractice liability insurance coverage in the amount specified in Wis. Stat. § [655.23\(4\)](#) prior to beginning patient care.

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Applicant Signature (If unable to provide a digital signature print and sign form.)	Date	

Upload this form directly into your LicensE application, <https://license.wi.gov/>.