



PODIATRY AFFILIATED CREDENTIALING BOARD
Room 121A, 1400 East Washington Avenue, Madison
Contact: Tom Ryan (608) 266-2112
October 20, 2016

The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.

AGENDA

9:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

A) Adoption of Agenda (1-3)

B) Approval of Minutes of June 28, 2016 (4-7)

C) Administrative Updates

- 1) Department and Staff Updates
- 2) Board Members – Term Expiration Dates
 - a) Jeffery Giesking – 07/01/2020
 - b) Thomas Komp – 07/01/2017
 - c) William Weis – 07/01/2019
- 3) Appointments/Reappointments/Confirmations

D) Legislative/Administrative Rule Matters (8-19)

- 1) Proposals for Guidelines Regarding Best Practices in Prescribing Controlled Substances
 - a) Wisconsin Medical Examining Board Opioid Prescribing Guideline
- 2) Proposals for Pod 1 Relating to Licensure Requirements and Pod 4 Relating to Biennial Registration
 - a) Report from Thomas Komp Concerning Possible Updates to Pod 1 and 4
- 3) Update on CR 15-075 Relating to Overtreatment of Patients and CR 15-076 Relating to the Duty to Obtain Informed Consent
- 4) Update on Pending Legislation and Pending and Possible Rulemaking Projects

E) Speaking Engagement(s), Travel, or Public Relation Request(s) (20-21)

- 1) Invite from the National Board of Podiatric Medical Examiners (NBPME)

F) Education and Exam Matters – Discussion and Consideration

- 1) Lowering Continuing Education Requirements

G) Informational Items

H) Items Added After Preparation of Agenda:

- 1) Introductions, Announcements and Recognition
- 2) Election of Board Officers
- 3) Appointment of Board Liaison(s)
- 4) Administrative Updates
- 5) Nominations, Elections, and Appointments
- 6) Education and Examination Matters
- 7) Credentialing Matters
- 8) Practice Matters
- 9) Legislation/Administrative Rule Matters
- 10) Liaison Reports
- 11) Informational Items
- 12) Disciplinary Matters
- 13) Presentations of Petitions for Summary Suspension
- 14) Petitions for Designation of Hearing Examiner
- 15) Presentation of Proposed Stipulations, Final Decisions and Orders
- 16) Presentation of Proposed Final Decisions and Orders
- 17) Presentation of Interim Orders
- 18) Petitions for Re-Hearing
- 19) Petitions for Assessments
- 20) Petitions to Vacate Orders
- 21) Requests for Disciplinary Proceeding Presentations
- 22) Motions
- 23) Petitions
- 24) Appearances from Requests Received or Renewed
- 25) Speaking Engagement(s), Travel, or Public Relation Request(s)

I) Public Comments

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02(8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).

J) **Deliberation on Division of Legal Services and Compliance (DLSC) Matters**

- 1) Administrative Warnings
- 2) Proposed Stipulations, Final Decisions and Orders
- 3) **Case Closings**
 - a) 16 POD 004 **(22-24)**
 - b) 16 POD 006 **(25-27)**
 - c) 16 POD 007 **(28-30)**
 - d) 16 POD 008 **(31-33)**
 - e) 16 POD 010 **(34-36)**

K) Deliberation of Items Added After Preparation of the Agenda

- 1) Education and Examination Matters
- 2) Credentialing Matters
- 3) Disciplinary Matters
- 4) Monitoring Matters
- 5) Professional Assistance Procedure (PAP) Matters

- 6) Petitions for Summary Suspensions
- 7) Petitions for Designation of Hearing Examiner
- 8) Proposed Stipulations, Final Decisions and Orders
- 9) Administrative Warnings
- 10) Review of Administrative Warnings
- 11) Proposed Final Decisions and Orders
- 12) Matters Relating to Costs/Orders Fixing Costs
- 13) Case Closings
- 14) Proposed Interim Orders
- 15) Petitions for Assessments and Evaluations
- 16) Petitions to Vacate Orders
- 17) Remedial Education Cases
- 18) Motions
- 19) Petitions for Re-Hearing
- 20) Appearances from Requests Received or Renewed

L) Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

M) Open Session Items Noticed Above not Completed in the Initial Open Session

N) Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate

O) Ratification of Licenses and Certificates

ADJOURNMENT

NEXT MEETING DATE JANUARY 19, 2017

**PODIATRY AFFILIATED CREDENTIALING BOARD
VIRTUAL/TELECONFERENCE MEETING MINUTES
June 28, 2016**

PRESENT: Jeffery Giesking, DPM; Thomas Komp, DPM; William Weis, DPM

STAFF: Tom Ryan - Executive Director; Nifty Lynn Dio - Bureau Assistant; and other
Department staff

CALL TO ORDER

The Chair called the meeting to order at 9:00 a.m. A quorum of three (3) members was confirmed.

ADOPTION OF AGENDA

Amendments to the Agenda:

- *Correction: Item D.1: Changing 2016 to 2015*
- *Correction: Item D.2: Changing 15-076 to 15-075*

MOTION: Jeffery Giesking moved, seconded by Thomas Komp, to adopt the agenda as amended. Motion carried unanimously.

APPROVAL OF MINUTES OF FEBRUARY 9, 2016

MOTION: Thomas Komp moved, seconded by Jeffery Giesking, to approve the minutes of February 9, 2016 as published. Motion carried unanimously.

LEGISLATIVE/ADMINISTRATIVE RULE MATTERS

**Update on 2015 Wisconsin Act 269 Relating to the Board's Authority to Issue Guidelines
Regarding Best Practices in Prescribing Controlled Substances and Proposals for Podiatry Board
Guidelines**

*National Transportation Safety Board (NTSB) Safety Recommendations for Prescribing Controlled
Substances – Discussion and Consideration*

MOTION: William Weis moved, seconded by Thomas Komp, to table the update on 2015 Wisconsin Act 269 and any drafting of guidelines until the next meeting. Motion carried unanimously.

Adoption Order for CR 15-075 Relating to Overtreatment of Patients

MOTION: Thomas Komp moved, seconded by Jeffery Giesking, to approve the Adoption Order for Clearinghouse Rule 15-075 relating to overtreatment of patients. Motion carried unanimously.

Adoption Order for CR 15-076 Relating to the Duty to Obtain Informed Consent

MOTION: Thomas Komp moved, seconded by Jeffery Giesking, to approve the Adoption Order for Clearinghouse Rule 15-076 relating to the duty to obtain informed consent. Motion carried unanimously.

Proposals for Chs Pod 1 and 4

MOTION: William Weis moved, seconded by Jeffery Giesking, to delegate Thomas Komp to review Chapters Pod 1 and 4 for possible updates for presentation at the next meeting. Motion carried unanimously.

CLOSED SESSION

MOTION: Thomas Komp moved, seconded by Jeffery Giesking, to convene to Closed Session to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85 (1)(b), and 448.02(8), Stats.); to consider individual histories or disciplinary data (s. 19.85 (1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.). The Chair read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Jeffery Giesking-yes; Thomas Komp-yes; and William Weis-yes. Motion carried unanimously.

The Board convened into Closed Session at 9:30 a.m.

RECONVENE TO OPEN SESSION

MOTION: William Weis moved, seconded by Jeffery Giesking, to reconvene in Open Session. Motion carried unanimously.

The Board reconvened into Open Session at 10:09 a.m.

**VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION,
IF VOTING IS APPROPRIATE**

MOTION: William Weis moved, seconded by Thomas Komp, to affirm all Motions made and Votes taken in Closed Session. Motion carried unanimously.

MOTION: Jeffery Giesking moved, seconded by Thomas Komp, to authorize Tom Ryan to sign DLSC Documents relating to compliance matters on today's agenda on the Board's behalf. Motion carried unanimously.

FULL BOARD REVIEW

Elenora Williams, D.P.M.

MOTION: Jeffery Giesking moved, seconded by Thomas Komp, to approve the application of Elenora Williams, D.P.M. for a full Wisconsin Podiatry License, once all requirements are met. Motion carried unanimously.

**DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC)
MATTERS**

Administrative Warnings

14 POD 005 – M.J.N.

MOTION: William Weis moved, seconded by Jeffery Giesking, to issue an Administrative Warning in the matter of DLSC Case No. 14 POD 005 against M.J.N. Motion carried unanimously.

16 POD 010 – A.A.R.

MOTION: Jeffery Giesking moved, seconded by Thomas Komp, not to issue an Administrative Warning in the matter of DLSC Case No. 16 POD 010 against A.A.R. Motion carried unanimously.

Proposed Stipulations, Final Decisions and Orders

15 POD 001 – Keith A. Beck, D.P.M.

MOTION: William Weis moved, seconded by Thomas Komp, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Keith A. Beck, D.P.M. DLSC Case No. 15 POD 001. Motion carried unanimously.

15 POD 008 – Robert R. Jacobs, D.P.M.

MOTION: Thomas Komp moved, seconded by William Weis, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Robert R. Jacobs, D.P.M. DLSC Case No. 15 POD 008. Motion carried unanimously.

16 POD 001 – Richard A. Arbetter, D.P.M.

MOTION: William Weis moved, seconded by Jeffery Giesking, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Richard A. Arbetter, D.P.M. DLSC Case No. 16 POD 001. Motion carried unanimously.

16 POD 009 – Patricia A. Pietz, D.P.M.

MOTION: William Weis moved, seconded by Thomas Komp, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Patricia A. Pietz, D.P.M. DLSC Case No. 16 POD 009. Motion carried unanimously.

Case Closings

14 POD 005

MOTION: Jeffery Giesking moved, seconded by William Weis, to close case 14 POD 005 (C.J.M.) for *No Violation*. Motion carried unanimously.

**DELEGATION OF RATIFICATION OF EXAMINATION RESULTS
AND RATIFICATION OF LICENSES AND CERTIFICATES**

MOTION: William Weis moved, seconded by Jeffery Giesking, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: William Weis moved, seconded by Thomas Komp, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:13 a.m.

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Dale Kleven Administrative Rules Coordinator		2) Date When Request Submitted: 10/10/16 Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Podiatry Affiliated Credentialing Board			
4) Meeting Date: 10/20/16	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Legislation and Rule Matters – Discussion and Consideration 1. Proposals for Guidelines Regarding Best Practices in Prescribing Controlled Substances a. Wisconsin Medical Examining Board Opioid Prescribing Guideline 2. Proposals for Pod 1 Relating to Licensure Requirements and Pod 4 Relating to Biennial Registration a. Report From Thomas Komp Concerning Possible Updates to Pod 1 and 4 3. Update on CR 15-075 Relating to Overtreatment of Patients and CR 15-076 Relating to the Duty to Obtain Informed Consent 4. Update on Pending Legislation and Pending and Possible Rulemaking Projects	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No		9) Name of Case Advisor(s), if required:
10) Describe the issue and action that should be addressed: 			
11) Authorization			
<i>Dale Kleven</i>		<i>October 10, 2016</i>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			



Wisconsin Medical Examining Board Opioid Prescribing Guideline

Scope and purpose of the guideline: To help providers make informed decisions about acute and chronic pain treatment -pain lasting longer than three months or past the time of normal tissue healing. The guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care. Although not specifically designed for pediatric pain, many of the principals upon which they are based could be applied there, as well.

Opioids pose a potential risk to all patients. The guideline encourages providers to implement best practices for responsible prescribing which includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients.

1) Identify and treat the cause of the pain, use non-opioid therapies

Use non-pharmacologic therapies (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) and non-opioid pharmacologic therapies (such as acetaminophen and anti-inflammatories) for acute and chronic pain. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

2) Start low and go slow

When opioids are used, prescribe the lowest possible effective dosage and start with immediate-release opioids instead of extended-release/long-acting opioids. Only provide the quantity needed for the expected duration of pain.

3) Close follow-up

Regularly monitor patients to make sure opioids are improving pain and function without causing harm. If benefits do not outweigh harms, optimize other therapies and work with patients to taper or discontinue opioids, if needed.

What's included in the guideline?

The guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, treating the cause of the pain, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the guideline include:

1) Determining when to initiate or continue opioids

- Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
- Establishment of treatment goals
- Discussion of risks and benefits of therapy with patients

2) Opioid selection, dosage, duration, follow-up and discontinuation

- Selection of immediate-release or extended-release and long-acting opioids
- Dosage considerations
- Duration of treatment
- Considerations for follow-up and discontinuation of opioid therapy

3) Assessing risk and addressing harms of opioid use

- Evaluation of risk factors for opioid-related harms and ways to mitigate/reduce patient risk
- Review of prescription drug monitoring program (PDMP) data
- Use of urine drug testing
- Considerations for co-prescribing benzodiazepines
- Arrangement of treatment for opioid use disorder

Prescription Opioid Guideline

1. Pain is a subjective experience and at present, physicians lack options to objectively quantify pain severity other than by patient reported measures including pain intensity. While accepting the patient's report of pain, the clinician must simultaneously decide if the magnitude of the pain complaint is commensurate with causative factors and if these have been adequately evaluated and addressed with non-opioid therapy.

2. In treating acute pain, if opioids are at all indicated, the lowest dose and fewest number of opioid pills needed should be prescribed. In most cases, less than 3 days' worth are necessary, and rarely more than 5 days' worth. Left-over pills in medicine cabinets are often the source for illicit opioid abuse in teens and young adults. When prescribing opioids, physicians should consider writing two separate prescriptions for smaller amounts of opioids with specific refill dates, rather than a single large prescription. Most patients do not fill the second prescription, thus limiting opioid excess in a patient's home and potential misuse.

3. A practitioner's first priority in treating a patient in pain is to identify the cause of the pain and, if possible, to treat it. While keeping the patient comfortable during this treatment is important, it is critical to address to the extent possible the underlying condition as the primary objective of care.

a. Patients unwilling to obtain definitive treatment for the condition causing their pain should be considered questionable candidates for opioids. If opioids are prescribed to such patients, documentation of clear clinical rationale should exist.

b. Opioids should not be prescribed unless there is a medical condition present which would reasonably be expected to cause pain severe enough to require an opioid. For conditions where this is questionable, use of other treatments instead of opioids should be strongly considered.

c. Consultation should be considered if diagnosis of and/or treatment for the condition causing the pain is outside of the scope of the prescribing practitioner.

4. Opioids should not necessarily be the first choice in treating acute or chronic pain.

a. Acute pain: Evidence for opioids is weak. Other treatments such as acetaminophen, anti-inflammatories, and non-pharmacologic treatments should be attempted prior to initiating opioid

therapy. Although opioids could be simultaneously prescribed if it is apparent from the patient's condition that he/she will need opioids in addition to these. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

b. Acute pain lasting beyond the expected duration: A complication of the acute pain issue (surgical complication, nonunion of fracture, etc.) should be ruled out. If complications are ruled out, a transition to non-opioid therapy (tricyclic antidepressant, serotonin/norepinephrine re-uptake inhibitor, anticonvulsant, etc.) should be attempted.

c. Chronic pain: Evidence for opioids is poor. Other treatments such as acetaminophen, anti-inflammatories, and non-pharmacologic treatments (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) should be utilized. Multiple meta-analyses demonstrate that the benefits of opioids are slight, while annualized mortality rates dramatically increased. There are few if any treatments in medicine with this poor a risk/benefit ratio, and there should be adequate clinical indication to indicate why chronic opioid therapy was chosen in a given patient. **Note:** There is no high-quality evidence to support opioid therapy longer than 6 months in duration. Despite this fact, it is considered acceptable although not preferable to continue patients on treatment who have been on chronic opioid therapy prior to this Guideline's release and who have shown no evidence of aberrant behavior.

d. Patients unwilling to accept non-pharmacological and/or nonnarcotic treatments (or those providing questionably credible justifications for not using them) should not be considered candidates for opioid therapy.

5. Patients should not receive opioid prescriptions from multiple physicians. There should be a dedicated provider such as a primary care or pain specialist to provide all opioids used in treating any patient's chronic pain, with existing pain contracts being honored. Physicians should avoid prescribing controlled substances for patients who have run out of previously prescribed medication or have had previous prescriptions lost or stolen.

6. Physicians should avoid using intravenous or intramuscular opioid injections for patients with exacerbations of chronic non-cancer pain in the emergency department or urgent care setting.

7. Physicians are encouraged to review the patient's history of controlled substance prescriptions using the Wisconsin Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. As of April, 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three-day supply.

8. Pain from acute trauma or chronic degenerative diseases can oftentimes be managed without opioids prior to surgery. Surgical patients using opioids preoperatively have higher complications rates, require more narcotics postoperatively, and have lower satisfaction rates with poorer outcomes following surgery.

9. Prescribing of opioids is not encouraged in patients concurrently taking benzodiazepines or other respiratory depressants. Benzodiazepines triple the already high increases in annual mortality rates from opioids. If they are used concurrently, clear clinical rationale must exist.

10. The use of oxycodone is discouraged. There is no evidence to support that oxycodone is more effective than other oral opioids, while there are multiple studies indicating that oxycodone is more abused and has qualities that would promote addiction to a greater degree than other opioids. As a result, oxycodone should not be considered first-line and should be used only in patients who cannot tolerate other opioids and who have been evaluated for and found not to demonstrate increased risk of abuse.

11. Patients presenting for chronic pain treatment should have a thorough evaluation, which may include the following:

- a.** Medical history and physical examination targeted to the pain condition
- b.** Nature and intensity of the pain
- c.** Current and past treatments, with response to each treatment
- d.** Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e., renal disease, sleep apnea, COPD, etc.)
- e.** Effect of pain on physical and psychological functioning
- f.** Personal and family history of substance abuse
- g.** History of psychiatric disorders associated with opioid abuse (bipolar, ADD/ADHD, sociopathic, borderline, untreated/severe depression)
- h.** Medical indication(s) for use of opioids.

12. Initiation of opioids for chronic pain should be considered on a trial basis. Prior to starting opioids, objective symptomatic and functional goals should be established with the patient. If after a reasonable trial these goals are not met, then opioids should be weaned or discontinued.

13. Practitioners should always consider the risk-benefit ratio when deciding whether to start or continue opioids. Risks and benefits should be discussed with patients prior to initiating chronic opioid therapy, and continue to be reassessed during that therapy. If evidence of increased risk develops, weaning or discontinuation of opioids should be considered. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be discontinued and the patient should be treated for withdrawal, if needed.

a. Exceptions to this include patients with unstable angina and pregnant patients, especially in the 3rd trimester (withdrawal could precipitate pre-term labor).

b. Components of ongoing assessment of risk include:

- i.** Review of the Prescription Drug Monitoring Program (PDMP) information
- ii.** Periodic urine drug testing (including chromatography) – at least yearly in low risk cases, more frequently with evidence of increased risk
- iii.** Periodic pill counts – at least yearly in low risk cases, more frequently if evidence of increased risk
- iiii.** Violations of the opioid agreement

- 14.** All patients on chronic opioid therapy should have informed consent consisting of:
- a.** Specifically detailing significant possible adverse effects of opioids, including (but not limited to) addiction, overdose, and death
 - b.** Treatment agreement, documenting the behaviors required of the patient by the prescribing practitioner to ensure that they are remaining safe from these adverse effects
- 15.** Initial dose titration for both acute and chronic pain should be with short-acting opioids. For chronic therapy, it would be appropriate once an effective dose is established to consider long-acting agents for a majority of the daily dose.
- 16.** Opioids should be prescribed in the lowest effective dose. This includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients. If daily doses for chronic pain reach 50 morphine milligram equivalents (MMEs), additional precautions should be implemented (see #13.b. above). Given that there is no evidence base to support efficacy of doses over 90 MMEs, with dramatically increased risks, dosing above this level is strongly discouraged, and appropriate documentation to support such dosing should be present on the chart.
- 17.** The use of methadone is not encouraged unless the practitioner has extensive training or experience in its use. Individual responses to methadone vary widely; a given dose may have no effect on one patient while causing overdose in another. Metabolism also varies widely and is highly sensitive to multiple drug interactions, which can cause accumulation in the body and overdose. For a given analgesic effect, the respiratory depressant effect is much stronger compared to other opioids. Finally, methadone can have a potent effect on prolonging the QTc, predisposing susceptible patients to potentially fatal arrhythmias.
- 18.** Prescribing of opioids is strongly discouraged for patients abusing illicit drugs. These patients are at extremely high risk for abuse, overdose, and death. If opioids are prescribed to such patients, a clear and compelling justification should be present.
- 19.** During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks. During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.
- 20.** Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk, including:
- a.** History of overdose (a relative contraindication to chronic opioid therapy)
 - b.** Opioid doses over 50 MMEs/day
 - c.** Clinical depression
 - d.** Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.)

The recommended dose is 0.4 mg for IM or intranasal use, with a second dose available if the first is ineffective or wears off before EMS arrives. Family members can be prescribed naloxone for use with the patient.

21. All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder. As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner should be able to assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an addiction treatment center which is willing to accept the patient. Simply discharging a patient from the provider's practice after prescribing the medication that led to the complication of opioid use disorder is not considered acceptable.

22. Discontinuing Opioid Therapy

A. If lack of efficacy of opioid therapy is determined, discontinuation of therapy should be performed.

1. Opioid weaning can be performed by reducing the MED by 10% weekly until 5-10mg MED remain at which time the opioid can be fully discontinued.

2. Prescription of clonidine 0.2 mg po BID or tizanidine 2mg po TID can be provided to patients complaining of opioid withdrawal related symptoms.

B. If evidence of increased risk develops, weaning or discontinuation of opioid should be considered.

1. Opioid weaning can be performed by reducing the MED by 25% weekly until 5-10mg MED remain at which time the opioid can be fully discontinued.

2. Prescription of clonidine 0.2 mg po BID or tizanidine 2mg po TID can be provided to patients complaining of opioid withdrawal related symptoms.

3. Physicians can consider weekly or bi-monthly follow-up during the weaning process.

C. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be immediately discontinued and the patient should be treated for withdrawal, if needed.

1. Exceptions to abrupt opioid discontinuation include patients with unstable angina and pregnant patients. These patients should be weaned from the opioid medications in a gradual manner with close follow-up.

Resources

CDC Guideline for Prescribing Opioids for Chronic Pain--United States 2016. Dowell D1, Haegerich TM1, Chou R1., JAMA. 2016 Apr 19;315(15):1624-45. doi:10.1001/jama.2016.1464.

Chronic Opioid Clinical Management Guidelines for Wisconsin Worker's Compensation Patient Care. <https://dwd.wisconsin.gov/wc/medical/pdf/CHRONIC%20OPIOID%20CLINICAL%20MANAGEMENT%20GUIDELINES%20.pdf>

Within-subject comparison of the psychopharmacological profiles of oral oxycodone and oral morphine in non-drug-abusing volunteers. Zaczyny, James, & Lichtor, Stephanie. *Psychopharmacology* (2008) 196:105-116

Subjective, Psychomotor, and Physiological Effects Profile of Hydrocodone/Acetaminophen and Oxycodone/Acetaminophen Combination Products. Zaczyny, James, & Gutierrez, Sandra. *Pain Medicine* (2008) Vol 9, No 4: 433-443

Positive and Negative Subjective Effects of Extended-Release Oxycodone versus Controlled-Release Oxycodone in Recreational Opioid Users. Schoedel, Kerri et. al. *Journal of Opioid Management* 7:3 May/June 2011. 179-192

Tapentadol Abuse Potential: A Postmarketing Evaluation Using a Sample of Individuals Evaluated for Substance Abuse Treatment. Stephen F. Butler, PhD et. al., *Pain Medicine* 2015; 16: 119–130

Methadone Safety: A Clinical Practice Guideline from the American Pain Society and College on Problems of Drug Dependence, in collaboration with the Heart Rhythm Society. Chou R1, et. al., *J Pain*. 2014 Apr;15(4):321-37

Emerging Issues in the Use of Methadone. SAMHSA Substance Abuse Treatment Advisory, Spring 2009, Volume 8, Issue 1, available at <http://store.samhsa.gov/shin/content//SMA09-4368/SMA09-4368.pdf>

Opioid Use, Misuse, and Abuse in Orthopedic Practice. American Academy of Orthopedic Surgeons, Information Statement 1045, October, 2015, available at <http://www.aaos.org/PositionStatements/Statement1045/?ssopc=1>

Wisconsin Medical Society Opioid Prescribing Principles. <https://www.wisconsinmedicalsociety.org/advocacy/boards-councils/society-initiatives/opioid-task-force/opioid-prescribing-principles/>

Chapter Pod 1

LICENSE TO PRACTICE PODIATRIC MEDICINE AND SURGERY

Pod 1.01	Authority and purpose.
Pod 1.02	Definitions.
Pod 1.03	Application and credentials.
Pod 1.04	Translation of documents.
Pod 1.05	Application deadline and fees.
Pod 1.06	Examinations.

Pod 1.07	Failure and reexamination.
Pod 1.08	Temporary educational license.
Pod 1.09	Locum tenens license.
Pod 1.10	Temporary license.
Pod 1.11	Examination review by applicant.
Pod 1.12	Board review of examination error claim.

Pod 1.01 Authority and purpose. Chapters Pod 1 to 6 are adopted by the podiatry affiliated credentialing board under ss. 15.085 (5) (b), 227.11 (2) and 448.695, Stats., and govern the practice of podiatric medicine and surgery under subch. IV of ch. 448, Stats.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00; correction made under s. 13.92 (4) (b) 6., Stats., Register September 2012 No. 681.

Pod 1.02 Definitions. As used in chs. Pod 1 to 7:

- (1) “Board” means the podiatry affiliated credentialing board.
 (2) “Controlled substance” has the meaning under s. 961.01 (4), Stats.

(2m) “Direct supervision” means a podiatric physician has assumed responsibility for directing, supervising, and inspecting the work of the person being supervised and the supervising podiatric physician is physically present on the same premises as the person being supervised, with face-to-face contact as necessary.

(3) “License” means any license issued by the board.

(4) “Licensee” means any person validly possessing any license granted and issued to that person by the board.

(5) “Patient” means a person who receives health care services from a podiatrist.

(6) “Patient health care record” has the meaning given in s. 146.81 (4), Stats.

(6m) “Podiatric x-ray assistant” means a person who is under the direct supervision of a licensed podiatric physician and who performs only those radiographic functions that are within the scope of practice of a podiatric physician licensed under s. 448.61, Stats., and that the podiatric physician is competent to perform.

(7) “Practitioner” means a person holding a license to practice podiatric medicine and surgery.

(8) “Prescription drug” has the meaning under s. 450.01 (20), Stats.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00; CR 06-056: am. (2) Register April 2007 No. 616, eff. 5-1-07; correction in (2) made under s. 13.93 (2m) (b) 7., Stats., Register April 2007 No. 616; correction in (1) made under s. 13.92 (4) (b) 6., Stats., Register September 2012 No. 681; CR 13-110: am. (intro.), cr. (2m), (6m) Register August 2014 No. 704, eff. 9-1-14.

Pod 1.03 Application and credentials. Every person applying for a license to practice podiatric medicine and surgery shall make application on forms provided by the board and shall submit all of the following:

- (1) A completed and verified application form.
 (2) Verified documentary evidence of graduation from a school of podiatric medicine and surgery approved by the board and a verified photographic copy of the diploma conferring the degree of doctor of podiatric medicine or its equivalent as determined by the board granted to the applicant by the school. The board shall approve the podiatric medical schools recognized and approved at the time of the applicant’s graduation by the council on education of the American podiatric association.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00.

Pod 1.04 Translation of documents. If any of the documents required under this chapter are in a language other than English, the applicant shall also submit a verified English translation and the cost of translation shall be borne by the applicant.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00.

Pod 1.05 Application deadline and fees. The completed application and all required documents shall be received by the board at its offices not less than 30 days prior to the date of examination. The required fees under s. 440.05 (1), Stats., shall accompany the application.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00.

Pod 1.06 Examinations. (1) (a) An applicant shall complete the written examination under sub. (2), and an open book examination on statutes and rules governing the practice of podiatric medicine and surgery in Wisconsin. In addition, an applicant may be required to complete an oral examination if the applicant:

1. Has a medical condition which in any way impairs or limits the applicant’s ability to practice podiatric medicine and surgery with reasonable skill and safety.

2. Uses chemical substances so as to impair in any way the applicant’s ability to practice podiatric medicine and surgery with reasonable skill and safety.

3. Has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction.

4. Has been found negligent in the practice of podiatric medicine or has been a party in a lawsuit in which it was alleged that the applicant had been negligent in the practice of podiatric medicine.

5. Has been convicted of a crime the circumstances of which substantially relate to the practice of podiatric medicine.

6. Has lost, had reduced or had suspended his or her hospital staff privileges, or has failed to continuously maintain hospital privileges during the applicant’s period of licensure following postgraduate training.

7. Has been graduated from a school of podiatric medicine not approved by the board.

8. Has been diagnosed as suffering from pedophilia, exhibitionism or voyeurism.

9. Has within the past 2 years engaged in the illegal use of controlled substances.

10. Has been subject to adverse formal action during the course of medical education, postgraduate training, hospital practice, or other medical employment.

11. Has not practiced podiatric medicine and surgery for a period of 6 months prior to application, unless the applicant has been graduated from a school of podiatric medicine within that period.

(b) An application filed under s. Pod 1.03 shall be reviewed by an application review panel of at least 2 board members designated by the chairperson of the board. The panel shall determine

whether the applicant is eligible for a license without completing an oral examination.

(c) All examinations shall be conducted in the English language. Each examination is scored separately, and the applicant shall achieve passing scores on each examination to qualify for a license.

(2) The board shall utilize as its written examinations the national board examination, part I and part II, and the PMLexis examination of the national board of podiatric examiners. The passing scores are set by the national board of podiatric medicine and represent the minimum competency required to protect public health and safety. The board may accept the recommendations of the examination provider.

(3) The board may deny release of scores or issuance of a credential if the board determines that the applicant violated rules of conduct of the examination or otherwise acted dishonestly in the examination process.

(4) An applicant who has received passing grades in written examinations for a license to practice podiatry conducted by another licensing jurisdiction of the United States, shall submit to the board documentary evidence. The board shall review the documentary evidence to determine whether the scope and passing grades of the examinations are substantially equivalent to those of this state at the time of the applicant's examination. If the board finds equivalency, the board shall accept this in lieu of requiring the applicant to achieve passing grades in the national board examination and the PMLexis examination of the national board of podiatry examiners. The burden of proof of equivalency is on the applicant.

(5) The oral examination of each applicant is conducted by members of the board and is scored as pass or fail.

(6) The board shall notify each applicant found eligible for examination of the time and place scheduled for that applicant's oral examination. Unless prior scheduling arrangements have been made with the board by the applicant, failure of an applicant to appear for examination as scheduled shall void that applicant's application and require the applicant to reapply for licensure.

(7) Any applicant who is a graduate of a school of podiatric medicine and surgery in which English is not the primary language of communication shall be examined by the board on his or her proficiency in the English language.

(8) Otherwise qualified applicants with disabilities, as defined by the Americans with disabilities act, shall be provided with reasonable accommodations.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00.

Pod 1.07 Failure and reexamination. An applicant who fails to achieve a passing grade in the examinations required under this chapter may apply for reexamination. An applicant who fails to achieve a passing grade in the examinations required under this chapter may be reexamined twice at not less than 4 month intervals. If the applicant fails to achieve a passing grade on the second reexamination, the applicant shall not be admitted to further examination until he or she reapplies for licensure and also presents to the board evidence of further professional training or education as the board may deem appropriate in each applicant's particular case.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00.

Pod 1.08 Temporary educational license. (1) An applicant who has been appointed to a postgraduate training program in a facility in this state approved by the board may apply to the board for a temporary educational license to practice podiatric medicine and surgery and shall submit to the board all of the following:

(a) A completed and verified application form provided by the board.

Note: Applications are available upon request to the board office located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

(b) The documentary evidence and credentials required under ss. Pod 1.04, 1.05 and 1.06.

(c) The required fees under s. 440.05 (1), Stats.

(2) An applicant shall complete an open book examination on statutes and rules governing the practice of podiatric medicine and surgery in Wisconsin.

(3) The holder of a temporary educational license to practice podiatric medicine and surgery may, under the direction of a person licensed to practice podiatric medicine and surgery in this state, perform services requisite to the training program in which that holder is serving. Acting under such direction, the holder of a temporary educational license shall also have the right to prescribe drugs other than controlled substances and to sign any certificates, reports or other papers for the use of public authorities which are required of or permitted to persons licensed to practice podiatric medicine and surgery. The holder of a temporary educational license shall confine his or her entire practice to the facility in which he or she is taking the training.

(4) Violation by the holder of a temporary educational license to practice podiatric medicine and surgery of any of the provisions of chs. Pod 1 to 6 or of subch. IV of ch. 448, Stats., which apply to persons licensed to practice podiatric medicine and surgery, shall be cause for the revocation of the temporary educational license.

(5) Temporary educational licenses granted under this chapter shall expire 2 years from date of issuance.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00; CR 12-047: am. (5) Register March 2014 No. 699, eff. 4-1-14.

Pod 1.09 Locum tenens license. (1) An applicant who holds a valid license to practice podiatric medicine and surgery issued by another licensing jurisdiction of the United States may apply to the board for a locum tenens license to practice podiatric medicine and surgery and shall submit to the board all of the following:

(a) A completed and verified application form provided by the board.

Note: Applications are available upon request to the board office located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

(b) A letter from a podiatrist licensed to practice podiatric medicine and surgery in this state requesting the applicant's services.

(c) A verified photostatic copy of a license to practice podiatric medicine and surgery issued by another licensing jurisdiction of the United States to the applicant.

(d) The required fees under s. 440.05 (1), Stats.

(2) An applicant shall complete an open book examination on statutes and rules governing the practice of podiatric medicine and surgery in Wisconsin.

(3) The application and documentary evidence submitted by the applicant shall be reviewed by the board, acting through a designated member of the board and, upon the finding of the member that the applicant is qualified, the board, acting through the designated member, shall issue a locum tenens license to practice podiatric medicine and surgery to the applicant.

(4) The holder of a locum tenens license to practice podiatric medicine and surgery shall practice podiatric medicine and surgery as defined in s. 448.60 (4), Stats., providing the practice is confined to the geographical area for which the license is issued.

(5) A locum tenens license to practice podiatric medicine and surgery shall expire 90 days from the date of its issuance. For cause shown to its satisfaction, the board, acting through its designated member, may renew the locum tenens license for additional periods of 90 days each, but no license may be renewed more than 3 consecutive times.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00; CR 06-056: am. (4) Register April 2007 No. 616, eff. 5-1-07; correction in (4) made under s. 13.93 (2m) (b) 7., Stats., Register April 2007 No. 616.

Pod 1.10 Temporary license. (1) (a) An applicant for a license to practice podiatric medicine and surgery who is a graduate of a school of podiatric medicine and surgery approved by the board may apply to the board for a temporary license to practice podiatric medicine and surgery. An applicant for a temporary license shall submit to the board the documentary evidence and credentials required under ss. Pod 1.04 and 1.05, a completed application for a temporary license, and the required fees under s. 440.05 (1), Stats. An application for a temporary license shall be made not less than 30 days before the date set by the board for the holding of its next examinations for licensure.

(b) The application and information submitted under par. (a), shall be reviewed by the board through a designated member. The board, acting through the designated member, shall issue a temporary license to practice podiatric medicine and surgery if the applications and information submitted under par. (a) are satisfactory.

Note: Applications are available upon request to the board office located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

(2) (a) A temporary license to practice podiatric medicine and surgery granted under this section expires on the earliest of the following dates:

1. Sixty days after the next examination for a license is given by the board if the temporary licensee submits to the examination.

2. The first day the board begins its examination of applicants for a license to practice podiatric medicine and surgery after the temporary license is issued, if the temporary licensee does not submit to the examination on that date.

3. The date following the examination on which the board grants or denies the temporary licensee a license to practice podiatric medicine and surgery.

(b) A license to practice podiatric medicine and surgery is deemed denied by the board under par. (a) 3., on the date the applicant is notified that he or she has failed the examination for a license to practice podiatric medicine and surgery.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00.

Pod 1.11 Examination review by applicant. (1) An applicant who fails the oral examination or statutes and rules examination may request a review of that examination by filing a written request and the required fee under s. 440.05 (1), Stats., with the board within 30 days of the date on which examination results were mailed.

(2) Examination reviews are by appointment only.

(3) An applicant shall review the statutes and rules examination for not more than one hour.

(4) An applicant shall review the oral examination for not more than 2 hours.

(5) An applicant shall not be accompanied during the review by any person other than the proctor.

(6) At the beginning of the review, the applicant shall be provided with a copy of the questions, a copy of the applicant's answer sheet or oral tape and a copy of the master answer sheet.

(7) An applicant shall review the examination in the presence of a proctor. The applicant shall be provided with a form on which to write comments, questions or claims of error regarding any items in the examination. Bound reference books shall be permitted. An applicant shall not remove any notes from the area. Notes shall be retained by the proctor and made available to the applicant for use at a hearing, if desired. The proctor shall not defend the examination or attempt to refute claims of error during the review.

(8) An applicant shall not review the examination more than once.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00.

Pod 1.12 Board review of examination error claim.

(1) An applicant claiming examination error shall file a written request for board review in the board office within 30 days of the date the examination was reviewed. The request shall include all of the following:

(a) The applicant's name and address.

(b) The type of license for which the applicant applied.

(c) A description of the mistakes the applicant believes were made in the examination content, procedures, or scoring, including the specifics or procedures claimed to be in error.

(d) The facts which the applicant intends to prove, including reference text citations or other supporting evidence for the applicant's claim.

(2) The board shall review the claim, make a determination of the validity of the objections and notify the applicant in writing of the board's decision and any resulting grade changes.

(3) If the board confirms the failing status following its review, the application shall be deemed incomplete and the board shall issue a notice of denial.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00.

Chapter Pod 4

BIENNIAL REGISTRATION

Pod 4.01 Registration required; method of registration.
Pod 4.02 Registration prohibited, annulled; reregistration.

Pod 4.03 Failure to be registered.
Pod 4.04 License reinstatement.

Pod 4.01 Registration required; method of registration. Each licensee shall register biennially with the board. Prior to November 1 of each even-numbered year the department shall mail to each licensee at his or her last known address an application form for registration. Each licensee shall complete the application form and return it with the required fee prior to November 1 of that year. The board shall notify the licensee within 30 business days of receipt of a completed registration form whether the application for registration is approved or denied.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00; CR 14-065: am. Register March 2016 No. 723, eff. 4-1-16.

Pod 4.02 Registration prohibited, annulled; reregistration. Any podiatrist required to comply with the provisions of s. 448.665, Stats., and of ch. Pod 3, and who has not so complied, shall not be permitted to register. Any person whose license has been suspended or revoked shall not be permitted to register, and the registration of any person shall be automatically annulled upon the effective date of the board's order suspending or revoking the license. A person whose license has been suspended or revoked and subsequently restored shall be reregistered by the board upon receipt by the board of a completed registration form.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00.

Pod 4.03 Failure to be registered. (1) A licensee who fails for whatever reason to be registered as required under this chapter shall not exercise the rights or privileges conferred by any license granted by the board.

(2) Failure to renew a license by November 1 of an even-numbered year shall cause the license to lapse. A licensee who allows the license to lapse may apply to the board for reinstatement of the license as follows:

(a) If the licensee applies for renewal of the license less than 5 years after its expiration, the license shall be renewed upon payment of the renewal fee and fulfillment of the continuing education requirements.

(b) If the licensee applies for renewal of the license more than 5 years after its expiration, the board shall make an inquiry to determine whether the applicant is competent to practice under the license in this state, and shall impose any reasonable conditions on the renewal of the license, including oral examination, as the board deems appropriate. All applicants under this paragraph shall be required to pass the open book examination on statutes and rules, which is the same examination given to initial applicants. This section does not apply to licensees who have unmet disciplinary requirements or whose licenses have been surrendered or revoked.

History: Cr. Register, January, 2000, No. 529, eff. 2-1-00; CR 14-065: am. (2) (intro.) Register March 2016 No. 723, eff. 4-1-16; CR 15-076: am. (2) (b) Register July 2016 No. 727, eff. 8-1-16.

Pod 4.04 License reinstatement. A licensee who has unmet disciplinary requirements and failed to renew a license within 5 years of the renewal date or whose license has been surrendered or revoked may apply to have a license reinstated if the applicant provides all of the following:

(1) Evidence of completion of requirements in s. Pod 4.03 **(2)** (b) if the licensee has not held an active Wisconsin license within the last 5 years.

(2) Evidence of completion of disciplinary requirements, if applicable.

(3) Evidence of rehabilitation or a change in circumstances, warranting reinstatement of the license.

History: CR 15-076: cr. Register July 2016 No. 727, eff. 8-1-16; correction in (1) made under s. 35.17, Stats., Register July 2016 No. 727.

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Nifty Lynn Dio, Bureau Assistant On behalf of Tom Ryan, Executive Director		2) Date When Request Submitted: 10/14/2016 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Podiatry Affiliated Credentialing Board			
4) Meeting Date: 10/20/2016	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Speaking Engagements, Travel, or Public Relation Requests	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: <p>From: Federation of Podiatric Medical Boards Sent: Friday, August 12, 2016 10:18 AM To: Russell Stoner (FPMB) Subject: FPMB - NBPME CSPE Standard Setting Invitation</p> <p>Good morning and happy Friday!</p> <p>Please forward this invitation from the National Board of Podiatric Medical Examiners (NBPME) to your podiatrist board members:</p> <p>The NBPME is actively searching for leaders among the podiatric medical profession to be members of a standard setting panel for the APMLE Part II Clinical Skills Patient Encounter (CSPE), the clinical skills examination component of the American Podiatric Medical Licensing Examination. You are being invited either because you are a residency director, are a recent graduate, or <u>have served on a state licensing board</u>. The panel will convene on November 18-19, 2016 for a workshop at the NBOME National Center for Clinical Skills Testing, 101 West Elm Street, Conshohocken, PA. The purpose of the workshop is to help make a decision for the cut scores for the examination.</p> <p>During the standard setting sessions, panelists will be asked to evaluate actual examinee performances and make expert judgments which will be used in calculating the passing standard. Expert panelists will receive a thorough orientation and training regarding the process at the meeting. Therefore, no experience in setting standards is necessary.</p> <p>The NBPME will pay for coach airfare, hotel room, ground transportation and a per diem of \$100.00 for each day, including travel days. In addition we provide you with an honorarium of \$200.00 for the workshop. The NBPME will reserve your room at the Residence Inn, Conshohocken, PA. The room will be requested as non-smoking with a king size bed for your arrival on November 17th and departure on November 20th. As a participant, you are required to arrive the Thursday evening before the sessions and remain until Sunday morning.</p>			

**State of Wisconsin
Department of Safety & Professional Services**

For more information on the examination, including a link to the informational program video, visit the NBPME’s website at <http://www.apmle.com/about-the-exam/part-ii-cspe/>. The dress code for the workshop is business casual.

Please respond with your availability as soon as possible. We have specific proportions of recent graduates, residency directors and licensing board members that we are attempting to meet. If you have any questions or would like to participate, please e-mail Ellen Veruete at nbpme@comcast.net. I hope your busy schedule will permit you to join us. Your participation would be appreciated!

You may call Kriegner Travel (1-800-257-0412 or 1-609-737-9393) for your airline reservations.

Thank you,

Phil Park

Executive Director, NBPME

11)

Authorization

Nifty Lynn Dio

10/14/2016

Signature of person making this request

Date

Supervisor (if required)

Date

Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date

Directions for including supporting documents:

1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.