

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935

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1400 E. Washington Avenue
Madison, WI 53703

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MEDICAL EXAMINING BOARD

PERFUSIONIST EMPLOYMENT VERIFICATION FORM

IMPORTANT: PLEASE FORWARD THIS FORM TO ALL EMPLOYERS DURING THE LAST 10 YEARS (This form may be photocopied).

The State of Wisconsin requests that you complete this form concerning the following individual:

PERFUSIONIST'S NAME: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S TELEPHONE: _____

1. What position did this perfusionist hold when employed by you? _____

2. What were this perfusionist's dates of employment? _____

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 3. Did this person perform perfusionist duties while employed by you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Did this perfusionist leave your employ in good standing?
If no, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Was the perfusionist on probation, suspended or in any way sanctioned/disciplined while employed by you?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Was this perfusionist granted a leave of absence while employed by you?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Were any restrictions or special requirements placed on this perfusionist's activities which were not placed on all other employees holding similar positions?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Was this perfusionist denied hospital privileges while employed by you?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Were any restrictions or special requirements placed on this perfusionist's hospital privileges?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Were any formal patient or staff complaints filed against this perfusionist?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |

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- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 11. Were any incident reports filed involving the professional conduct or behavior of this perfusionist?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Was this perfusionist ever subject to a non-routine monitoring while in your employ?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Was this perfusionist removed from a call schedule for cause?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |

Print name of Employer Supplying Information _____

Signature of Employer Supplying Information _____

Date form was completed _____

PLEASE ATTACH LETTERHEAD FROM THE FACILITY WHERE THE APPLICANT WORKED OR SUPPLY SOME FORM OF IDENTIFICATION FOR INDIVIDUAL SUPPLYING INFORMATION.

Please return directly to:

Department of Safety and Professional Services
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935