

Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
 Madison, WI 53705
 Phone Number: (608) 266-2112

LicensE Portal: <https://license.wi.gov/>
 Email: dps@wisconsin.gov
 Website: <http://dps.wi.gov>

EXAMINING BOARD OF PROFESSIONAL GEOLOGISTS, HYDROLOGISTS, AND SOIL SCIENTISTS

SUPERVISED EXPERIENCE EVALUATION FORM

Instructions: All applicants applying for registration must document a minimum of two (2) years of professional work performed under the supervision of a licensed professional or under the supervision of another person whom the Board determines is qualified to have responsible charge of work. This form (**Form #2913**) must be completed by a licensed professional who has supervised or has firsthand knowledge of the applicant's relevant work experience relating to the profession. Failure to provide the requested information will result in denial of licensure.

APPLICANT: Complete Page 1 of this form and forward it to Supervisor Evaluator. Proper completion of this form (**Form#2913**) is required for application processing. Any alteration made to the form will void the form.

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

Type Credential Applying For: Geologist Hydrologist Soil Scientist

Name of Applicant's Employer at Time of Experience	Dates of Employment (month/year)
	From ____/____/____ To ____/____/____

Business Address of Employer (street, city, state, zip code)	Total Experience (month/year)
	From ____/____/____ To ____/____/____

Name of Supervisor	Percent of Time (100% if full time)

Applicant should make explicit statements listing and defining work performed and projects for which he/she had full or partial responsibility, including statement of extent and complexity of work performed. (Attach additional sheets if necessary.)

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

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

Wisconsin Department of Safety and Professional Services

SUPERVISOR EVALUATOR: Complete Page 2 The applicant named above has filed an application for licensure with the State of Wisconsin. This registration depends, among other considerations, on the verification of the extent, diversity, and quality of his/her practical training and experience under a licensed professional or persons the Board determines is qualified to have responsible charge of work as described on Page 1 by the applicant. Please assist by supplying the information requested based upon your own personal, first-hand knowledge of the applicant. (Attach additional sheets if needed.) Return form directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number on Page 1. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

Last Name of Supervisor Evaluator	First Name	Title		
Name of Firm		Nature of Current Business		
Address of Firm (number/street)		(city)	(state)	(zip code)
A supervisor evaluator must meet the requirements as a professional as stated under Wis. Stat. ch. 470. Please list your professional certification, credential (license) or registration.				
Type	Issuing State or Organization	Credential #	Year Issued	
			□ □ □ □	
			□ □ □ □	
Please verify the work product the applicant described on page 1 of this form. State your opinion regarding the accuracy of the description, including duration, extent and complexity of work and indicate your evaluation of the applicant's performance. (Attach additional sheets if needed.)				
Are there any items of the described experience which you cannot verify? If so, please explain.				
Additional Comments (if any)				
ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.				
Supervisor Evaluator's Signature (If unable to provide a digital signature print and sign form.)			Date	
			□ □ / □ □ / □ □ □ □	
Daytime Phone Number (with area code)	_____ - _____ - _____ Extension _____			