

# Wisconsin Department of Safety and Professional Services

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## MEDICAL EXAMINING BOARD

### MEDICAL EXAMINING BOARD COMPACT AFFIDAVIT

#### AFFIDAVIT OF APPLICANT

I declare that I am not, to the best of my knowledge, under investigation by the Drug Enforcement Administration, any law enforcement agency, facility that grants privileges, medical board, or any other entity not listed here.

I understand that making any materially false statement and/or giving any materially false information in connection with my application to obtain a Letter of Qualification from the Wisconsin Medical Examining Board shall be deemed a violation of the Wisconsin Medical Practice Act and the Wisconsin Administrative Code and may result in disciplinary action.

By signing below, I am signifying that I have read the above statements and understand the obligation I have as a credential-holder should information I have provided to the Department of Safety and Professional Services change.

Applicant's Printed Full Name:

Signature:

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

Date (mm/dd/yyyy):

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