

# Wisconsin Department of Safety and Professional Services

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LicensE Portal: <https://license.wi.gov/>  
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 Website: <http://dsps.wi.gov>

## MEDICAL EXAMINING BOARD PERFUSIONIST EMPLOYMENT VERIFICATION FORM

**IMPORTANT:** Form is required for all employers in the 10 years immediately preceding date of applicant's credentialing application.

<b>APPLICANT: Complete this section and submit directly to your employer for completion. Form must be returned <u>directly from the employer to the Department.</u></b>			
<b>Perfusionist's Name:</b>			
<b>Employer's Name:</b>			
<b>Employer's Address:</b> (number/street)	(city)	(state)	(zip code)
<b>Employer's Phone:</b>			
<p><b>ATTESTATION OF APPLICANT:</b> 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.</p>			
<b>Applicant Signature</b> (If unable to provide a digital signature, print and sign form.)	<b>Date</b> (mm/dd/yyyy)	<b>Application Number</b>	
	___/___/_____		

<p><b>EMPLOYER: Complete this section for the above-named applicant and return directly to the Department using the License Third-Party* Upload Portal at <a href="https://license.wi.gov">license.wi.gov</a>. You will need the application number shown above. (*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.)</b></p>		
1.	What position did this perfusionist hold when employed by you?	
2.	What were this perfusionist's dates of employment? (If currently employed, please check "to present" instead of "to" date.) <b>From</b> ___/___/_____ <b>To</b> ___/___/_____ <input type="checkbox"/> <b>To Present</b>	
3.	Did this person perform perfusionist duties while employed by you?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
4.	Did this perfusionist leave your employ in good standing? <b>If no, please attach explanation on a separate sheet.</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
5.	Was the perfusionist on probation, suspended or in any way sanctioned/disciplined while employed by you? <b>If yes, please attach explanation on a separate sheet.</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
6.	Was this perfusionist granted a leave of absence while employed by you? <b>If yes, please attach explanation on a separate sheet.</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
7.	Were any restrictions or special requirements placed on this perfusionist's activities which were not placed on all other employees holding similar positions? <b>If yes, please attach explanation on a separate sheet.</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
8.	Was this perfusionist denied hospital privileges while employed by you? <b>If yes, please attach explanation on a separate sheet.</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

*Continued on next page.*

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*Employer completion, continued.*

9.	Were any restrictions or special requirements placed on this perfusionist's hospital privileges? <b>If yes, please attach explanation on a separate sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Were any formal patient or staff complaints filed against this perfusionist? <b>If yes, please attach explanation on a separate sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Were any incident reports filed involving the professional conduct or behavior of this perfusionist? <b>If yes, please attach explanation on a separate sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Was this perfusionist ever subject to a non-routine monitoring while in your employ? <b>If yes, please attach explanation on a separate sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Was this perfusionist removed from a call schedule for cause? <b>If yes, please attach explanation on a separate sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**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.

<b>Signature of Employer</b> (If unable to provide a digital signature, print and sign form.)	<b>Date</b> (mm/dd/yyyy)
	____ / ____ / _____
<b>Employer Printed Name</b>	<b>Phone Number</b>
<b>Title</b>	