Wisconsin Department of Safety and Professional Services

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

LicensE Portal: License.wi.gov
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

LICENSE TRANSITION ADDENDUM

Complete the appropriate section (A or B) below and return form directly to the Department.

PLEASE PRINT IN INK	☐ Your name, address, phone number, and email address are available to the public. Check box to withhold street address/PO Box, phone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).		
License Holder Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**

Wisconsin License #:

Type of License: (check one): ☐ MD ☐ DO

SECTION A: This section applies to an individual who currently holds a Physician credential and is submitting a request to transition the credential to an Administrative Physician credential.

Please read carefully and sign/date below.

☐ I understand that per Wis. Admin. Code § Med 23.04 I may no longer examine, care for, or treat patients. I no longer have the authority to prescribe drugs or controlled substances, delegate medical acts, issue opinions regarding medical necessity, or conduct clinical trials on humans.

☐ I understand that my current license will expire, and I will be issued a new license upon completion of my license transition.

☐ I understand that the grant date of the Administrative Physician license will be the same as the grant date of my original Physician license.

☐ I understand that I am subject to all Wisconsin laws and rules regarding Administrative Physicians.

Signature: _____ **Date:** __/__/____
(If unable to provide a digital signature print and sign form.)

SECTION B: This section applies to an individual who currently holds an Administrative Physician credential and is requesting to transition the credential to a Physician credential.

Please read carefully and sign/date below.

☐ I understand that the Medical Examining Board will review my petition to return to active practice and may request additional information or an appearance before the Board to determine eligibility.

☐ I understand that the current license will expire, and I will be issued a new license upon completion of my license transition.

☐ I understand that the grant date of the Physician license will be the same as the grant date of my Administrative Physician license.

☐ I understand that the restrictions per Wis. Admin. Code § Med 23.04 remain in effect until the time that my license has transitioned.

☐ I understand that I am subject to all Wisconsin laws and rules regarding Physicians.

☐ My last date of active practice was __/__/____.

Signature: _____ **Date:** __/__/____
(If unable to provide a digital signature print and sign form.)