Wisconsin Department of Safety and Professional Services

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PODIATRY AFFILIATED CREDENTIALING BOARD

TEMPORARY EDUCATIONAL LICENSE - AFFIDAVIT OF HOSPITAL AUTHORITY

APPLICANT: Complete this section and submit it to the training program. Form must be returned directly from the training program to the Department.

Applicant Name:	
Application Number:	
Name of Hospital:	

Hospital Address: (number/street)	(city)	(state)	(zip code)

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.)	**Date** (mm/dd/yyyy)
	_____/_____/_____

HOSPITAL/FACILITY: The above-listed applicant has made application for postgraduate training in this hospital under the provision of a Temporary Educational License, which will entitle him/her to receive training under the direction of a licensed Wisconsin podiatrist for a period not to exceed two (2) years (Wis. Admin. Code § Pod 1.08(5)). **Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. 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.)

I have examined the credentials of the applicant listed above and find that he/she meets the requirements of the Podiatry Affiliated Credentialing Board regulations governing these licenses, and is satisfactory to this hospital. I hereby recommend that the Board consider this application for a Temporary Educational License with his/her postgraduate training to begin as stated below.

Start Date of Training: _____/_____/_____ (mm/dd/yyyy)

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.

Printed Name of licensed WI Podiatrist:	**WI Podiatric Med & Surg Lic Number:**	**Title:**

Signature[1] of WI Podiatrist:	**Date:** (mm/dd/yyyy)	**Phone:**
	_____/_____/_____	

[1]If unable to provide a digital signature, please print and sign form.