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

MEDICAL EXAMINING BOARD

OUT OF STATE PHYSICIAN TEMPORARY CAMP PRACTICE NOTIFICATION FORM

Pursuant to Wis. Stat. § 448.033, you may practice medicine and surgery to provide treatment to campers and staff for not more than 90 days in any year without holding a license granted under Wis. Stat. ch. 448, Subch. II if all of the following apply:

- The recreational or educational camp is licensed under Wis. Stat. § 97.67(1),
- You are licensed in good standing to practice medicine and surgery by another state or territory of the United States or a Canadian province or territory and the licensure standards in the jurisdiction where you are licensed are substantially equivalent to the requirements for licensure as a physician under Wis. Stat. § 448.04(1)(a),
- You are not under active investigation by a licensing authority or law enforcement authority in any state, federal, or foreign jurisdiction, and
- You submit this form to the Wisconsin Medical Examining Board before practicing.

IMPORTANT NOTE: If practice will exceed 90 days in any year, please see Form #568, Application for Temporary Camp Physician or Locum Tenens License.

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PLEASE TYPE OR PRINT IN INK ☐ Your name, address, phone number, and e-mail 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).

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

Date of Birth (mm/dd/yyyy) __/__/____

Daytime Telephone Number ___-___-____ Ext____

Country ☐ U.S./territory ☐ Canada

Address (unit number and street) (city) (state, province, or territory) (zip or postal code)

Mailing Address (if different) (unit number and street) (city) (state, province, or territory) (zip or postal code)

E-mail Address

Social Security Number/Social Insurance Number ___-___-____

The Department may not disclose the Social Security Number (U.S./territory) or Social Insurance Number (Canada/territory) collected except as authorized by law.

Ethnicity/gender status information is optional.

GENDER ☐ M ☐ F

ETHNICITY: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Hispanic ☐ Other

CAMP INFORMATION

Camp Name **Full Name of Camp Contact**

Camp Address (street) (city) (state) (zip code)

Camp Contact E-mail Address **Camp Contact Phone Number** ___-___-____ Ext_____

List Dates of Practice (Cannot exceed 90 days in any year.)

Answer the following: (Attach additional sheets if necessary.)

1.	I attest that the camp listed above is a recreational or educational camp licensed under Wis. Stat. § 97.67(1). **If no, you do not meet requirements to practice in a camp setting under Wis. Stat. § 448.033.**	☐ Yes ☐ No
2.	Have you ever been credentialed in Wisconsin? **If yes, list your credential number_____.**	☐ Yes ☐ No
3.	I attest that I am licensed in good standing to practice medicine and surgery by another state or territory of the United States or a Canadian province or territory. **If yes, list all that apply.** (Attach additional sheets if necessary.)	☐ Yes ☐ No

License Type	Jurisdiction	Credential Number	Expiration Date (mm/dd/yyyy)
			__/__/____
			__/__/____
			__/__/____

If no, you do not meet requirements to practice in a camp setting under Wis. Stat. § 448.033.

Wisconsin Department of Safety and Professional Services

4.	Of the **licenses listed in Question 3,** I attest that the jurisdiction(s) I list below have licensure standards that are substantially equivalent to the requirements for licensure as a physician in Wisconsin under Wis. Stat. § 448.04(1)(a): **If no, you do not meet requirements to practice in a camp setting under Wis. Stat. § 448.033.**	☐ Yes ☐ No
5.	I attest that I am not under active investigation by a licensing authority or law enforcement authority in any state, federal, or foreign jurisdiction. **If no, you do not meet requirements to practice in a camp setting under Wis. Stat. § 448.033.**	☐ Yes ☐ No
6.	I understand that under Wis. Stat. § 448.033, camp practice may not exceed 90 days in any year.	☐ Yes ☐ No

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure. If information I have provided on this form becomes invalid, incorrect, or outdated, I understand that I am obliged to provide any necessary information to ensure the information on this form remains current, valid, and truthful. I understand that the Wisconsin Medical Examining Board may view acts of omission as dishonesty.

AFFIDAVIT

I declare that I am the person referred to on this form and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement, and/or giving any materially false information in connection with my submission of this form may result in Wisconsin Medical Examining Board action or penalties as may be provided by law.

By signing below, I am attesting that I have read the above statements (Continuing Duty of Disclosure and Affidavit) and understand the obligation I have should information I have provided to the Department of Safety and Professional Services change.

Print full name: _____

Signature: _____ **Date:** ____/____/____

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