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

VERIFICATION OF POST-GRADUATE TRAINING REL RENEWAL RECOMMENDATION FORM

Applicant: Please complete top section of this form and forward to your postgraduate training facility. Ask the facility to return the completed form directly to the Department.

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

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 or 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)**
Current REL License Number -851		**Application Number (Starting with PAR) PAR -**	
Current Address (number, street)	(city)	(state)	(zip code)
Facility Name		**REL Expiration Date** __ __ / __ __ / __ __ __ __	

I would like to make application for renewal of my Resident Educational License issued to allow me to secure post-graduate training at the facility listed above. I request permission for my training to continue for the period of an additional twelve months from the expiration date stated above. During the past year, I have conducted my activities at this facility according to the limitations placed upon them by Wis. Stat. § 448.04(1)(bm) and by the regulations of the Medical Examining Board.

Applicant Signature: _____ **Date:** __ __ / __ __ / __ __ __ __

(Provide a digital signature or print and sign form.)

This section must be completed by the President or Dean of the postgraduate training program only if the applicant has been/will be accepted to continue in the postgraduate training program accredited by the ACGME or AOA. 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 "ThirdParty" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

I hereby recommend the renewal of the **Resident Educational License** for the applicant and license number listed above, who has been employed in this facility for the past year as a postgraduate trainee in medicine and surgery under the provisions of Wis. Stat. § 448.04(1)(bm). This renewal shall extend the license for the period of an additional twelve months.

President/Dean Name: _____

Location of Facility: _____

(Street, City, State and Zip Code)

President/Dean Signature: _____ **Date**: __ __ / __ __ / __ __ __ __

(Provide a digital signature or print and sign form.)

Committed to Equal Opportunity in Employment and Licensing