PROGRAM AUTHORITY

Wis. Stat. § 440.077 (originating in 2021 Wis. Act 158) and Wis. Admin. Code chs. SPS 11 and MED 26. The Wisconsin Medical Examining Board (MEB) oversees program operations.

Wisconsin Department of Safety and Professional Services
Attn: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935
Questions? Visit our website http://dsps.wi.gov, email dsps@wisconsin.gov, or call (608) 266-2112

PARTNERS

Wisconsin Department of Safety and Professional Services (DSPS)

Wisconsin Department of Veterans Affairs (DVA), https://dva.wi.gov/Pages/Home.aspx

Wisconsin Board of Nursing (BON)

Wisconsin Medical Examining Board (MEB)

PROGRAM DESCRIPTION

Eligible military medical personnel (MMP) may temporarily perform certain skilled health services that otherwise would require a license while supervised in an administering facility without first obtaining one of the following licenses from the Wisconsin Department of Safety and Professional Services (DSPS) under applicable corresponding statutes. (Refer to Wis. Stat. § 440.077(2)(a).)

Registered Nurse (Wis. Stat. § 441.06)

Licensed Practical Nurse (Wis. Stat. § 441.10)

Physician, Perfusionist, Anesthesiologist Assistant, or Respiratory Care Practitioner (Wis. Stat. § 448.04)

Podiatrist (Wis. Stat. § 448.61)

Physician Assistant (Wis. Stat. § 448.974)

PROGRAM DEFINITIONS

Adequate Supervision - The licensed supervising practitioner is competent and authorized under his or her applicable license or certification to perform the delegated clinical act, and must have reasonable evidence that the supervised individual is minimally competent to perform the act under the circumstances.

Administering Facility - inpatient health care facility defined in Wis. Stat. § 50.135(1), an outpatient health care location, a community-based residential facility defined in Wis. Stat. § 50.01(1g), or a residential care apartment complex defined in Wis. Stat. § 50.01(6d), that is a party to the Memorandum of Understanding specified in Wis. Admin. Code § Med 26.03(1) and maintains a written policy governing MMP program participants specified in Wis. Admin. Code § Med 26.03(1)(g).

Basic Patient Care – care that can be performed following a defined procedure with minimal modification in which the responses of the patient to the care are predictable.

Basic Patient Situation - as determined by a licensed supervising practitioner means the following three conditions prevail at the same time in a given situation: (1) The patient's clinical condition is predictable; (2) Medical or nursing orders are not changing frequently and do not contain complex modifications; and (3) The patient's clinical condition requires only basic patient care.

Complex Patient Situation - as determined by a licensed supervising practitioner means any one or more of the following conditions exist in a given situation: (1) The patient's clinical condition is not predictable; (2) Medical or nursing orders are likely to involve frequent changes or complex modifications; or (3) The patient's clinical condition indicates care that is likely to require modification of procedures in which the responses of the patient to the care are not predictable.

Disease - any pain, injury, deformity, physical or mental illness, or departure from complete health or the proper condition of the human body or any of its parts.

Licensed Supervising Practitioner – (1) a physician, a physician assistant, or a podiatrist licensed under Wis. Stat. ch. 448; or (2) a registered nurse or certified advanced practice nurse prescriber authorized to issue prescription orders credentialed under Wis. Stat. ch. 441.

CONTINUED

PROGRAM DEFINITIONS CONTINUED

Military Medical Personnel (MMP) - means a person who served as an Army Medic, a Navy or Coast Guard Corpsman, or an Air Force Aerospace Medical Technician in the U.S. Armed Forces.

Military Medical Personnel Program Participant – means military medical personnel (MMP) who meet all program requirements under Wis. Admin. Code § Med 26.02(9).

Skilled Health Services – means any of the following: (1) To examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, by any means or instrumentality; (2) To apply principles or techniques of medical sciences in the diagnosis or prevention of any of the conditions in (1) or "Disease" above; (3) To penetrate, pierce, or sever the tissues of a human being; and (4) To offer, undertake, attempt, or hold oneself out in any manner as able to do any of the acts described in this paragraph. **Skilled health services do not include surgical procedures or issuing prescription orders.**

GENERAL PROGRAM REQUIREMENTS

(1) **MOU -** Before performing any services under the program, the MMP must complete and sign this Memorandum of Understanding (Form 7158) and submit it to the employer. The services to be provided must reflect the MMP's level of training and experience.
- Section 1 – MMP
- Section 2 – Supervisor(s) (All supervisors must be listed on Page 9. Rows one and two are reserved for practitioner(s) who will serve as core supervisor(s) for the MMP. ROW ONE MUST BE COMPLETED.
- Section 3 – Facility
- Military Medical Personnel Licensure Timeline (Form 7159) (Link below.)

(2) An MMP program participant must be supervised by a licensed supervising practitioner(s) who will retain responsibility for the care of their patient(s).

(3) Timeline – An MMP must establish a reasonable timeline with the employer in this MOU that describes the actions the MMP will take to acquire a license from DSPS. **Form 7159, Military Medical Personnel Licensure Timeline, must be submitted to DSPS.** (See form for details.)

IMPORTANT NOTE: An MMP Program Participant becomes ineligible to participate in the program beginning on the day after the date that the MMP agreed to acquire a license in the Military Medical Personnel Licensure Timeline (Form 7159).

The Medical Examining Board may extend the termination date of a signed Memorandum of Understanding if it appears that, because of unforeseen circumstances, the applicant requires more time to receive a license. Submit a narrative request to Wisconsin Department of Safety and Professional Services, Attn: Medical Examining Board, P.O. Box 8935, Madison, WI 53708-8935 or dsps@wisconsin.gov.

MILITARY MEDICAL PERSONNEL PROGRAM MEMORANDUM OF UNDERSTANDING

SECTION 1 – MILITARY MEDICAL PERSONNEL

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

Address (number/street)	(city)	(state)	(zip code)	**Daytime Phone Number**
				_____- _____- _____
Mailing Address (if different) (number/street)	(city)	(state)	(zip code)	**Date of Birth**
				☐☐/☐☐/☐☐☐☐

Social Security Number ☐☐☐-☐☐-☐☐☐☐	Your Social Security Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Ethnicity and gender status fields are 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

Email Address	

Have you ever been licensed as a healthcare professional in Wisconsin? ☐Yes ☐ No	**If YES, list profession and credential #**
Profession	#

1.	Have you served as an Army Medic, a Navy or Coast Guard Corpsman, or an Air Force Aerospace Medical Technician in the U.S. Armed Forces? **If YES, identify your type of service ☐ an Army Medic, ☐ a Navy or Coast Guard Corpsman, or ☐ an Air Force Aerospace Medical Technician. If NO, you do not qualify for the MMP Program.**	☐ Yes ☐ No
2.	Have you been discharged or released from the service identified in Question 1 in the previous 12 months under honorable or general conditions? **If YES,** • Provide discharge/release date ___ ___ / ___ ___ / ___ ___ ___ ___ and • Attach proof of military service and general or honorable discharge. **If NO, you do not qualify for the MMP Program.**	☐ Yes ☐ No
3.	Have you filed a signed MOU (Form 7158) with your employer? **If YES, note that this document must be made available to any licensed supervising practitioner prior to your initiating basic patient care (and available to the Medical Examining Board if requested). If NO, you do not qualify for the MMP Program.**	☐ Yes ☐ No
4.	Have you established a reasonable timeline (Form 7159) with your employer that describes the actions you intend to take to acquire a license including the date by which you agree to acquire the license? **If NO, you do not qualify for the MMP Program.**	☐ Yes ☐ No
5.	Have you submitted the timeline (Form 7159) noted in Question 4 above, to the Wisconsin Department of Safety and Professional Services (DSPS)? **If NO, you do not qualify for the MMP Program.**	☐ Yes ☐ No
6.	Do you acknowledge that you will become ineligible to participate in the program beginning on the day after the date that you agreed to acquire a license in the submitted Timeline (Form 7159)? (Read program information on Page 2 if needed.)	☐ Yes ☐ No
7.	Do you acknowledge that you may submit a request to the Medical Examining Board to extend the timeline termination date if it appears that, because of unforeseen circumstances, you require more time to receive a license? (Read information on Page 2 if needed.)	☐ Yes ☐ No
8.	Do you attest that you will not accept a delegation of practice authority to perform a clinical act if your training and experience did not include that clinical act? **If NO, you do not qualify for the MMP Program.**	☐ Yes ☐ No
9.	Do you acknowledge that the Medical Examining Board may receive and investigate complaints against an MMP program participant performing delegated clinical acts and that the Board may suspend or terminate an MMP participant's authority to perform delegated clinical acts?	☐ Yes ☐ No

SECTION 1 – MILITARY MEDICAL PERSONNEL (CONTINUED)

The services you provide at the facility must your level of training and experience. Provide the following information to assist the licensed supervising practitioner in making corresponding determinations.

- Structured Education and Training Programs (**attended before your military service)** (Table A): Provide details in Table A below *if applicable*. Examples include school course of study (with school name, city/state, and start/end dates) and certificates received for specific programs completed such as apprenticeships or specialization courses.
- Structured Education and Training Programs **attended during your military service** (Table B): Provide details in Table B below *if applicable*. Examples include service school or base course of study (with school or base name, city/state, and start/end dates) and certificates received for specific programs completed such as apprenticeships or specialization courses.
- Direct (hands-on) Training and Experience received while deployed (Table C): Provide details of direct hands-on training and experience while deployed in Table C below.
- Personal Narrative (Table D) (Optional): You may add any additional written personal narrative describing how your military education, training, and experience have prepared you for and directly correspond to services you will provide as outlined in this MOU if not otherwise detailed in Tables A, B, or C. You may also specify and describe any post-military service education, training, and experience you received, if applicable.

(**IMPORTANT NOTE**: If you would like your military training and experience considered when applying for a license, submit Form 2996**,** Veteran Request Application Addendum, to DSPS with your license application. (Do not submit Form 2996 with the MOU.)

Only complete tables that apply to your education, training, and experience.

TABLE A – STRUCTURED EDUCATION AND TRAINING PROGRAMS (ATTENDED PRIOR TO YOUR MILITARY SERVICE) (Attach additional sheets if needed.)		
School/Institution Name	**School Location (city)**	**School Location (state)**
Name of Program	**Start Date**	**Completion Date**
	__/__/____	__/__/____
Was a degree or certificate awarded? ☐Yes ☐ No (If yes, list)		
Describe the education/training (received before your military service) that prepared you to perform the duties outlined in this MOU. (Attach additional sheets if needed).		
School/Institution Name	**School Location (city)**	**School Location (state)**
Name of Program	**Start Date**	**Completion Date**
	__/__/____	__/__/____
Was a degree or certificate awarded? ☐Yes ☐ No (If yes, list)		
Describe the education/training (received before your military service) that prepared you to perform the duties outlined in this MOU. (Attach additional sheets if needed).		
School/Institution Name	**School Location (city)**	**School Location (state)**
Name of Program	**Start Date**	**Completion Date**
	__/__/____	__/__/____
Was a degree or certificate awarded? ☐Yes ☐ No (If yes, list)		

Describe the education/training (received before your military service) that prepared you to perform the duties outlined in this MOU. (Attach additional sheets if needed).

TABLE B - STRUCTURED EDUCATION AND TRAINING PROGRAMS ATTENDED DURING YOUR MILITARY SERVICE (Attach additional sheets if needed.)

School/Institution Name	**School Location (city)**	**School Location (state)**
Name of Program	**Start Date**	**Completion Date**
	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
Name of Military Base (if applicable)		
Was a degree or certificate awarded? ☐Yes ☐ No (If yes, list)		

Describe the hands-on education/training you received while you were deployed that prepared you to perform the duties outlined in this MOU. (Attach additional sheets if needed).

School/Institution Name	**School Location (city)**	**School Location (state)**
Name of Program	**Start Date**	**Completion Date**
	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
Name of Military Base (if applicable)		
Was a degree or certificate awarded? ☐Yes ☐ No (If yes, list)		

Describe the hands-on education/training you received while you were deployed that prepared you to perform the duties outlined in this MOU. (Attach additional sheets if needed).

School/Institution Name	**School Location (city)**	**School Location (state)**
Name of Program	**Start Date**	**Completion Date**
	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
Name of Military Base (if applicable)		
Was a degree or certificate awarded? ☐Yes ☐ No (If yes, list)		

Describe the hands-on education/training you received while you were deployed that prepared you to perform the duties outlined in this MOU. (Attach additional sheets if needed).

SECTION 1 – MILITARY MEDICAL PERSONNEL (CONTINUED)

TABLE C - DIRECT TRAINING AND EXPERIENCE (Attach additional sheets in the same format if needed.)		
Direct Training/Experience (Setting: ☐ Combat ☐ Noncombat)	**Training Location (city)**	**Training Location (state)**
Name of Program	**Start Date**	**Completion Date**
	__/__/____	__/__/____
Name of Military Base (if applicable)		
Was a degree or certificate awarded? ☐ Yes ☐ No (If yes, list)		
Describe the hands-on training and experience you received while you were deployed that prepared you to perform the duties outlined in this MOU. (Attach additional sheets if needed).		
Direct Training/Experience (Setting: ☐ Combat ☐ Noncombat)	**Training Location (city)**	**Training Location (state)**
Name of Program	**Start Date**	**Completion Date**
	__/__/____	__/__/____
Name of Military Base (if applicable)		
Was a degree or certificate awarded? ☐ Yes ☐ No (If yes, list)		
Describe the hands-on training and experience you received while you were deployed that prepared you to perform the duties outlined in this MOU. (Attach additional sheets if needed).		
Direct Training/Experience (Setting: ☐ Combat ☐ Noncombat)	**Training Location (city)**	**Training Location (state)**
Name of Program	**Start Date**	**Completion Date**
	__/__/____	__/__/____
Name of Military Base (if applicable)		
Was a degree or certificate awarded? ☐ Yes ☐ No (If yes, list)		
Describe the hands-on training and experience you received while you were deployed that prepared you to perform the duties outlined in this MOU. (Attach additional sheets if needed).		

SECTION 1 – MILITARY MEDICAL PERSONNEL (CONTINUED)

TABLE D – PERSONAL NARRATIVE (Optional): You may add any additional written personal narrative describing how your military education, training, and experience have prepared you for and directly correspond to services you will provide as outlined in this MOU if not otherwise detailed in Table A or Table B. You may also specify and describe any post-military service education, training, and experience you received, if applicable. (Attach additional sheets in the same format if needed.)

MMP ATTESTATION: I declare that I am the person referred to on this form and that all information required to be completed by me (the MMP), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that the form was completed with personnel from the facility listed in this MOU. 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 this MOU or my required related 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.

MMP Signature (If unable to provide a digital signature, please print and sign form.)	**Date**
	☐☐/☐☐/☐☐☐☐

SECTION 2 – SUPERVISOR(S)

Basic Patient Situations - Subject to the limitation in Wis. Stat. § 440.077(2)(b) and except as provided in § 440.077(5), the scope in which an MMP Program Participant may practice is limited to the performance of acts in basic patient situations under the general supervision of a licensed supervising practitioner, which includes the following: (See Pages 1 and 2 for definitions.)

Basic Patient Situations Service/Procedure
Accept only patient care assignments which the MMP Program Participant is competent to perform.
Provide basic patient care.
Record patient care given and report changes in the condition of a patient to the appropriate person.
Consult with a provider in cases where the MMP Program Participant knows or should know a delegated act may harm a patient.
Perform the following other acts when applicable: • Assist with the collection of data. • Assist with the development and revision of a patient care plan. • Reinforce the teaching provided by a licensed provider and provide basic health care instruction. • Participate with other health team members in meeting basic patient needs.

Complex Patient Situations, as determined by a licensed supervising practitioner, means any one or more of the following conditions exist in a given situation:

1) The patient's clinical condition is not predictable;
2) Medical or nursing orders are likely to involve frequent changes or complex modifications; or,
3) The patient's clinical condition indicates care that is likely to require modification of procedures in which the responses of the patient to the care are not predictable.

Acts delegated to an MMP Program Participant beyond basic patient care shall be performed under the **direct** supervision of a licensed supervising provider. The licensed supervising practitioner must be competent and authorized under his or her applicable license or certification to perform the delegated clinical act and must have reasonable evidence that the supervised individual is minimally competent to perform the act under the circumstances. (Note: An MMP Program Participant must provide documentation of competence (i.e., education, training, or experience, etc.) to the Medical Examining Board if requested.

Complex Patient Situations Service/Procedure
Licensed practicing supervisors may list any complex care activities they have agreed to directly supervise below. (Attach additional sheets if needed.)

Supervisor(s) Responsibilities		
1.	Do you attest that the MMP Program Participant will be supervised by a licensed physician, physician assistant, podiatrist, registered professional nurse, or advanced practice nurse prescriber? **If NO, program requirements are not met.**	☐ Yes ☐ No
2.	Do you acknowledge that the licensed supervising practitioner may rely on the MMP representations made specifying training and experience in the MOU as reasonable evidence of the individual's clinical training, experience, and competency to perform the delegated act?	☐ Yes ☐ No
3.	Do you attest that you have read and understand the definitions of basic and complex care defined in this MOU and that general and direct supervision will be provided accordingly? **If NO, program requirements are not met.**	☐ Yes ☐ No
4.	Do you acknowledge that the licensed supervising physician, physician assistant, podiatrist, registered professional nurse, or advanced practice nurse prescriber must retain responsibility for the care of the patient? **If NO, program requirements are not met.**	☐ Yes ☐ No
5.	Do you acknowledge awareness that an MMP Program Participant becomes ineligible to participate in the program beginning on the day after the date that the MMP agreed to acquire a license in the submitted Timeline Form (Form 7159) (Item 6, Page 2) and that the MMP may submit a request for an extension to the Medical Examining Board?	☐ Yes ☐ No

SECTION 2 – SUPERVISOR(S) (CONTINUED)

Instructions: Provide supervisor signatures in the rows below *as needed*. ***Rows one and two are reserved for practitioner(s) who will serve as a core supervisor(a) for the MMP. ROW ONE MUST BE COMPLETED.** Provide a digital signature or print and sign form. Attach additional sheets if needed.

ATTESTATION: I attest that I have read program requirements and have agreed to supervise the MMP Program Participant as outlined in this Memorandum of Understanding (MOU).

Attach additional sheets if needed.

1.	**Print Name of Licensed Supervising Practitioner (*CORE SUPERVISOR)**	**License Number**
	Signature of Licensed Supervising Practitioner	**Date Signed**
		☐☐/☐☐/☐☐☐☐
2.	**Print Name of Licensed Supervising Practitioner (*CORE SUPERVISOR)**	**License Number**
	Signature of Licensed Supervising Practitioner	**Date Signed**
		☐☐/☐☐/☐☐☐☐
3.	**Printed Name of Licensed Supervising Practitioner**	**License Number**
	Signature of Licensed Supervising Practitioner	**Date Signed**
		☐☐/☐☐/☐☐☐☐
4.	**Printed Name of Licensed Supervising Practitioner**	**License Number**
	Signature of Licensed Supervising Practitioner	**Date Signed**
		☐☐/☐☐/☐☐☐☐
5.	**Printed Name of Licensed Supervising Practitioner**	**License Number**
	Signature of Licensed Supervising Practitioner	**Date Signed**
		☐☐/☐☐/☐☐☐☐
6.	**Printed Name of Licensed Supervising Practitioner**	**License Number**
	Signature of Licensed Supervising Practitioner	**Date Signed**
		☐☐/☐☐/☐☐☐☐
7.	**Printed Name of Licensed Supervising Practitioner**	**License Number**
	Signature of Licensed Supervising Practitioner	**Date Signed**
		☐☐/☐☐/☐☐☐☐
8.	**Printed Name of Licensed Supervising Practitioner**	**License Number**
	Signature of Licensed Supervising Practitioner	**Date Signed**
		☐☐/☐☐/☐☐☐☐

SECTION 3 – FACILITY

FACILITY ATTESTATIONS	
By signing below, the facility administrator hereby attests to the following:	

• The administering facility has a written policy governing clinical practice by the MMP Program Participant and that policy is shared with:
  o the MMP Program Participant subject to the Memorandum of Understanding (MOU), and
  o those licensed supervising practitioners authorized to delegate clinical acts to the individual.
• To the best of the administering facility's knowledge and with a reasonable degree of certainty, all of the information in the MOU is true.	

Signature of Designated Facility Representative (Provide a digital signature print and sign form.)	**Date**
	☐☐/☐☐/☐☐☐☐
Printed Name	**Phone Number**
	☐☐☐-☐☐☐-☐☐☐☐
Title	
Email Address	