MILITARY MEDICAL PERSONNEL PROGRAM LICENSURE TIMELINE

This document, *Military Medical Personnel Timeline to Licensure* (#7159), must be submitted to the Wisconsin Department of Safety and Professional Services (DSPS) before performing any activity listed in the Memorandum of Understanding (Form 7158): Wisconsin Department of Safety and Professional Services (DSPS), P.O. Box 8935, Madison, WI 53708-8935 or dsps@wisconsin.gov. (After you submit your Timeline form, you must submit a professional license application via the DSPS online credentialing system, LicensE.)

PLEASE TYPE OR 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 email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).			
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.	**Name of Healthcare Institution in MOU**	**Healthcare Institution Contact**		
	Address (number/street)	(city)	(state)	(zip code)
	Institution Contact Email Address	**Institution Contact Phone Number**		
		☐☐☐-☐☐☐-☐☐☐☐		

4. **TYPE OF CREDENTIAL SOUGHT WITH TIMELINE (Check one): (General professional license requirements are listed on the PROFESSION webpage for each profession.)**

☐ **Anesthesiologist Assistant**	☐ **Physician Assistant**	☐ **Nurse, Licensed Practical (LPN)**
☐ **Perfusionist**	☐ **Podiatrist**	☐ **Nurse, Registered (RN)**
☐ **Physician** (select) ☐ **MD** ☐ **DO**	☐ **Respiratory Care Practitioner**	

MILITARY MEDICAL PERSONNEL PROGRAM LICENSURE TIMELINE (CONTINUED)

5.	**STEPS TO LICENSURE (Establish with your employer.)** IMPORTANT: If completion of any of the steps below is delayed and may impact the date provided in Item 6 below, request an extension promptly to avoid a disruption in your program eligibility. (See Item 6 for more information.)				**Goal for Completion (or N/A) (List as needed below.)**
	a.	**Provide the date on which you anticipate submitting your application for full professional licensure into the DSPS online credentialing system, LicensE. (Required)**			__/__/____
	b.	**Completion of all necessary education** ☐ **Not Applicable**			__/__/____
	c.	**Completion of all training** ☐ **Not Applicable**			__/__/____
	d.	**List the date(s) you intend to sit for any exam(s) that are required for professional licensure.** ☐ **Not Applicable**			
		Exam Name	**Date**	**Exam Name**	**Date**
	e.	**Receipt of national certification** ☐ **Not Applicable**			__/__/____
	Use additional rows, if needed. For example, if a licensure requirement is not listed above.				
	f.	**Other:**			__/__/____
	g.	**Other:**			__/__/____
	h.	**Other:**			__/__/____
	i.	**Other:**			__/__/____

6.	**DATE ON WHICH YOU AGREE TO ACQUIRE PROFESSIONAL LICENSURE. NOTE: APPLICATION DETERMINATIONS CANNOT BE MADE UNTIL ALL REQUIRED DOCUMENTATION IS RECEIVED AND REVIEWED BY DSPS. Additional documentation may be requested upon application review.**	__/__/____
	• **If a professional license is not granted by DSPS on the date entered in Item 6, the MMP Program Participant becomes INELIGIBLE to participate in the program THE DAY AFTER THAT DATE.** • 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 the Wisconsin Department of Safety and Professional Services, Attn: Medical Examining Board, P.O. Box 8935, Madison, WI 53708-8935 or dsps@wisconsin.gov.	

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 the Military Medical Personnel Memorandum of Understanding (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 submitted form 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 (Provide a digital signature or print and sign form.)	**Date**
	__/__/____