Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
Fax #: (608) 251-3036
Phone #: (608) 266-2112

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

CHIROPRACTIC EXAMINING BOARD

EMPLOYER VERIFICATION

(ENDORSEMENT APPLICANTS ONLY)

APPLICANT: Form is required for each employer where you engaged in the practice of chiropractic during the last five (5) years. Complete this section and forward to the employer. Form must be returned directly from the employer to the Department.

Applicant Name:	
Application Number:	
Name of Employer:	
Employer Address:	(number/street) (city) (state) (zip code)
Employer Phone:	

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. I hereby authorize the school/course provider named below to provide the Department with the information requested below. I hereby authorize the school named below to provide the Department with the information requested below.

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

EMPLOYER: 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.)

Employer must answer all of the following questions in order for this form to be considered complete.

1. What position did this applicant hold at your facility or under your employment?

2. What were this applicant's dates of employment? (If applicant is still employed, check "to present" instead of "to" date.)

From: __/__/____ To: __/__/____ ☐ "to present"

3. How many hours per week did the applicant work at your facility?

_____ Hours per Week

Continued on next page.

Wisconsin Department of Safety and Professional Services

Employer completion, continued.

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.

	__/__/____
Signature (If unable to provide a digital signature, please print and sign form.)	**Date**
	___-___-____ Ext_____
Printed Name	**Phone**
Title	