

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

4822 Madison Yards Way
Madison, WI 53705

E-Mail: web@dps.wi.gov
Website: <http://dps.wi.gov>

MEDICAL EXAMINING BOARD

REQUEST FOR A TEMPORARY LICENSE FOR PHYSICIAN ASSISTANT

NAME OF APPLICANT: (Please print): _____

Supervisor complete this section:

AFFIDAVIT OF SUPERVISING PHYSICIAN

I wish to request that a temporary license to practice as a physician assistant in the State of Wisconsin be issued to _____.

Print Name of Applicant

I am aware of all of the following requirements: a temporary license may not be renewed, an applicant holding a temporary license may apply for one transfer of supervising physician and location during the term of the temporary license, and that the temporary license will expire when any of the following occurs:

- 1) the date the board grants or denies an applicant permanent licensure.
- 2) the date the applicant is sent notice from that board that he or she has failed the examination required by sec. MED 8.05(1)(c).
- 3) the first day of the next regularly scheduled oral examination for permanent licensure (if the applicant is required to take, but failed to apply for, the examination).
- 4) applicant was selected to appear for the oral examination but failed to appear.
- 5) the date the applicant takes and fails the oral examination.

Signature and Title Supervising Physician (**Print and Sign Form**)

Agency/Department

Print Name and WI License Number

Street Address

() _____
Phone Number

City and State Zip

Date