Wisconsin Department of Safety and Professional Services

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MEDICAL EXAMINING BOARD

HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

APPLICANT: Complete this section and submit to all hospitals, facilities, and employers where you have had staff privileges, employment, or appointment during the last five (5) years. Form must be returned directly from the Hospital/Facility/Employer to the Department.

Applicant Name: _____ **Application Number:** _____

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 named below to provide the Department with the information requested below.

_____ **Applicant Signature** (If unable to provide a digital signature, print and sign form.)

__/__/____ **Date**

HOSPITAL/FACILITY/EMPLOYER: You must answer all of the following questions and provide any additional information in order for this form to be considered complete. Complete the section below 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.)

Applicant/Physician's Name _____

Name of Hospital/Facility/Employer _____

Hospital/Facility/Employer's Address _____

Hospital/Facility/Employer's Daytime Phone ___-___-____

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

_____

2. What were this physician's dates of employment or staff privileges at your facility? (Note: If physician is still employed/privileged, end date should indicate "to present.")

__/__/____ to __/__/____ **or** TO PRESENT ☐

3.	Did this physician either leave your employment in good standing or is currently employed and in good standing? **If no, please attach explanation on a separate sheet.**	☐ Yes ☐ No
4.	Was the physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No
5.	Was this physician granted a leave of absence while employed by you or at your facility? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No

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6.	Did this physician have a record of unexcused absences during his/her attendance at this facility or under your employment? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No
7.	Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees/staff holding similar positions? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No
8.	Were any restrictions placed on this physician's privileges? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No
9.	Were any formal patient or staff complaints filed against this physician? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No
10.	Was this physician denied hospital privileges while employed by you? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No
11.	Were any incident reports filed involving the professional conduct or behavior of this physician? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No
12.	Was this physician ever subject to non-routine monitoring while at your facility? **If yes, please attach explanation on a separate sheet.**	☐ Yes ☐ No
13.	Was this physician involuntarily removed from a call schedule for cause? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No
14.	Was this physician subject to non-routine quality assessment review? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No
15.	Was this physician the subject of a negative review by a quality assurance or departmental committee? **If yes, attach an explanation on a separate sheet.**	☐ Yes ☐ No

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 of Hospital/Facility/Employer
(If unable to provide a digital signature, please print and sign form.)

Date

Ext

Phone

Printed Name

Title