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: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

APPLICANT: **Please forward this form to all hospitals, facilities, and employers where you have had staff privileges, employment, or appointment during the last five (5) years.**

Hospital/Facility/Employer: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name: _____

Name of Hospital/Facility/Employer: _____

Hospital/Facility/Employer's Address: _____

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

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.

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?

__/__/__ to __/__/__ **NOTE: If Physician is still employed/privileged, end date should indicate "to present" or "to current."**

		YES	NO
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.**	☐	☐

If you answer Yes to questions 4-9, attach an explanation on a separate sheet.

4.	Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment?	☐	☐
5.	Was this Physician granted a leave of absence while employed by you or at your facility?	☐	☐
6.	Did this Physician have a record of unexcused absences during his/her attendance at this facility or under your employment	☐	☐
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?	☐	☐
8.	Were any restrictions placed on this Physician's privileges?	☐	☐
9.	Were any formal patient or staff complaints filed against this Physician?	☐	☐

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If you answer Yes to questions 10-15, attach an explanation on a separate sheet.

		YES	NO
10.	Was this Physician denied hospital privileges while employed by you?	☐	☐
11.	Were any incident reports filed involving the professional conduct or behavior of this Physician?	☐	☐
12.	Was this Physician ever subject to non-routine monitoring while at your facility?	☐	☐
13.	Was this Physician involuntarily removed from a call schedule for cause?	☐	☐
14.	Was this Physician subject to non-routine quality assessment review?	☐	☐
15.	Was this Physician the subject of a negative review by a quality assurance or departmental committee?	☐	☐

Name/title of Individual Supplying Information:

Signature: _____ Date ___/___/___

(Print and Sign Form)

Hospital/Facility/Employer, please return directly to:

DSPS
Attn: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Or you may fax/email with facility cover sheet/letter to: (608) 251-3036 or DSPSCredMedBD@wisconsin.gov**.**