

# 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](mailto: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."

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.**

	<b>YES</b>	<b>NO</b>
	<input type="checkbox"/>	<input type="checkbox"/>

**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?

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

5. Was this Physician granted a leave of absence while employed by you or at your facility?

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

6. Did this Physician have a record of unexcused absences during his/her attendance at this facility or under your employment?

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

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?

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

8. Were any restrictions placed on this Physician's privileges?

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

9. Were any formal patient or staff complaints filed against this Physician?

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

# Wisconsin Department of Safety and Professional Services

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

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

Name/title of Individual Supplying Information:

Signature: \_\_\_\_\_

Date  /  /

**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](mailto:DSPSCredMedBD@wisconsin.gov).