Wisconsin Department of Safety and Professional Services

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Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

VERIFICATION OF POST-GRADUATE TRAINING REL RENEWAL RECOMMENDATION FORM

Applicant: Please complete top section of this form and forward to your postgraduate training facility. Ask the facility to return the completed form directly to the Department.

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK ☐ Your name, address, phone number, and e-mail address are available to the public. Check box to withhold street address or PO Box, phone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**

Current REL License Number _____ -851 **REL Expiration Date** __ __ / __ __ / __ __ __ __

Current Address (number, street) (city) (state) (zip code)

Facility Name _____

I would like to make application for renewal of my Resident Educational License issued to allow me to secure postgraduate training at the facility listed above. I request permission for my training to continue for the period of an additional twelve months from the date expiration date stated above. During the past year, I have conducted my activities at this facility according to the limitations placed upon them by Wis. Stat. § 448.04(1)(bm) and by the regulations of the Medical Examining Board.

Applicant Signature: _____ **Date:** __ __ / __ __ / __ __ __ __
(Print and Sign Form)

This section must be completed by the President or Dean of the postgraduate training program only if the applicant has been/will be accepted to continue in the postgraduate training program accredited by the ACGME or AOA.

I hereby recommend the renewal of the **Resident Educational License** for the applicant and license number listed above, who has been employed in this facility for the past year as a postgraduate trainee in medicine and surgery under the provisions of Wis. Stat. § 448.04(1)(bm). This renewal shall extend the license for the period of an additional twelve months.

President/Dean Name: _____

Location of Facility: _____
(Street, City, State and Zip Code)

President/Dean Signature: _____ **Date**: __ __ / __ __ / __ __ __ __
(Print and Sign Form)

Permit fee: $10.00: Attach check or money order payable to DSPS. To pay by credit card, see Form #3071. (Multiple submissions will result in duplicate credit card charges.)

For Receipting Use Only (851)

Facility, please return directly to:
DSPS
ATTN: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935
Or facility may fax or e-mail form with facility cover sheet or cover letter to (608) 251-3036 or DSPSCredMedBD@wisconsin.gov.