Wisconsin Department of Safety and Professional Services

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MEDICAL EXAMINING BOARD

PHYSICIAN RESIDENT EDUCATIONAL LICENSE - AFFIDAVIT OF HOSPITAL AUTHORITY

The President/Dean or a delegate of the President/Dean of the training program must complete this form if the applicant has been or will be accepted into a postgraduate training program accredited by the ACGME/AOA.

APPLICANT: Complete this section and submit directly to the president/dean or a delegate of the president/dean of the training program for completion. Form must be returned directly from the president/dean or a delegate of the president/dean of the training program to the Department.

Applicant Name:	
Application Number:	
Name of Hospital:	
Address of Hospital:	

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.

Applicant Signature: (If unable to provide a digital signature, please print and sign form.)	**Date:**
	__/__/____

PRESIDENT/DEAN OR A DELEGATE OF THE PRESIDENT/DEAN OF THE TRAINING PROGRAM: Complete this section 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.)

The above-listed applicant has made application for postgraduate training in this Hospital under the provision of a Resident Educational License, which will entitle him or her to receive training under our supervision for a period not to exceed one (1) year, with renewals at the discretion of the Medical Examining Board, not to exceed four (4) additional years, upon recommendation of the Administrator of this hospital.

We have examined the credentials of the Physician listed above and find that he or she meets the requirements of the Medical Examining Board regulations governing these licenses, and are satisfactory to this Hospital. I hereby recommend that the Board consider this application for a Resident Educational License, with his or her postgraduate training to begin as stated below.

Start Date of Training:	__/__/____	**Training Program Phone Number:**	___-___-____

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.

Printed Name of President/Dean or delegate of the Program President/Dean:	**Title:**
Signature of President/Dean or delegate of the Program President/Dean:	**Date signed:**
	__/__/____