

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

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

MEDICAL EXAMINING BOARD

INFORMATION FOR COMPLETING APPLICATION FOR MEDICINE AND SURGERY FOR INDIVIDUALS WITH A CURRENT UNRESTRICTED MINNESOTA LICENSE

PLAN AHEAD: Applicants, recruiters, institutions, and others involved in the placement of individuals who seek to be credentialed in the state of Wisconsin should understand that the credentialing process takes time, and that credentialing is not guaranteed to any applicant. Factors that determine the length of time it may take to process an application include the length of time the applicant has been in practice, the total number of jurisdictions in which the applicant has been credentialed, and the length of time it takes for supporting documents to be received in the Board office and reviewed.

We strive to process applications in a timely fashion. We cannot issue a credential until all of the required documents have been received and reviewed in the Board office.

It is the Department's mission and legislative mandate to provide consumer protection for Wisconsin Residents. The Department and the Board have been asked to waive requirements to expedite the process, only to discover legitimate grounds to deny a credential. This can present a serious problem for the applicant, recruiter, or institutions if the applicant has relocated, purchased property, or made other commitments prior to the issuance of a Wisconsin credential. **We urge you not to make these moves until you know that your credential has been issued.**

Please "plan ahead" as we cannot speed up the credentialing process nor waive supporting documents even in emergency situations.

PLEASE READ BEFORE COMPLETING YOUR APPLICATION: This application **does not** apply to individuals who hold a MN Telemedicine license. To qualify for this license, you must currently hold an unrestricted State of Minnesota license. If you have ever held a Wisconsin physician license and the license has been expired more than 5 years, submit **Form 570** (not this form, #2862). If your Wisconsin physician license is expired less than 5 years, see <https://dsps.wi.gov/Pages/Professions/Physician/Default.aspx> for renewal information.

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- Application (**Form #2862**) and fees
- National Practitioner Data Bank Report
- Certification of Post Graduate Training (**Form #2165**)
- Copies of malpractice suit and court documents with allegations and settlement if applicable, complete Malpractice Suits or Claims (**Form #2829**)
- Authorization and Waiver (**Form #571**)
- Provide a current copy of your unrestricted Minnesota license
- Physician Profile Data Report from the American Medical Association or American Osteopathic Association
- Physician Data Center Practitioner Profile from the Federation of State Medical Boards (**Form #1445**)
- Convictions and Pending Charges (**Form #2252**) if applicable

VERIFICATION OF MEDICAL LICENSES IS REQUIRED: You are required to submit a current copy of your unrestricted Minnesota license to the Wisconsin Medical Examining Board.

NATIONAL PRACTITIONER DATA BANK: All candidates must request the "Practitioner Request for Information Disclosure" (Self-Query) from the National Practitioners Data Bank. Self-Queries (NPDB) can be found at <http://www.npdb.hrsa.gov/pract/selfQueryBasics.jsp>. Select the option that reads, "Start a Self-Query for an Individual." After the NPDB has completed your request, they will send the self-query response directly to you. Once received, you will need to forward a copy of the response to the Department. This report may be emailed to DSPSCREDMEDBD@wisconsin.gov, or faxed to (608) 251-3036. If you have further questions regarding this report, contact the NPDB helpline at 1-800-767-6732.

Wisconsin Department of Safety and Professional Services

PHYSICIAN PROFILE DATA REPORT FROM AMA OR AOA: All MD's applying for licensure must complete the Physician Profile Data Report. This request can be made from the following website: American Medical Association Physician Profile Data at: <https://profiles.ama-assn.org/amaprofiles/>. Please select the option for "Physicians Only Requests for Profiles to be sent to Licensing Boards" and follow the steps given on the AMA website.

All DO's applying for licensure must use the AOA website at <https://www.aoaprofiles.org/>.

PHYSICIAN DATA CENTER PRACTITIONER PROFILE REPORT: Request Report from the Federation of State Medical Boards (Form #1445).

ORAL INTERVIEWS:

The Oral Interview process in the State of Wisconsin was created under Wis. Admin. Code § MED 1.06. **If you are selected to appear for an Oral Interview**, you will be scheduled to appear before the Review Panel at one of the regularly scheduled Board meetings.

Panel Review: Oral Interviews:

- a) In addition to the National exam, an applicant **may** be required to complete an Oral Interview if the applicant:
1. Has a medical condition, which in any way impairs or limits the applicant's ability to practice medicine and surgery with reasonable skill and safety.
 2. Uses chemical substances to impair in any way the applicant's ability to practice medicine and surgery with reasonable skill and safety.
 3. Has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction.
 4. Has been found to be negligent in the practice of medicine or has been a party in a lawsuit in which it was alleged that the applicant had been negligent in the practice of medicine.
 5. Has been convicted of a crime the circumstances of which substantially relate to the practice of medicine.
 6. Has lost, had reduced, or had suspended his or her hospital staff privileges, or has failed to continuously maintain hospital privileges during the applicant's period of licensure following post-graduate training.
 7. Has graduated from a medical school not approved by the Board.
 8. Has been diagnosed as suffering from Pedophilia, Exhibitionism, or Voyeurism.
 9. Has within the past two (2) years engaged in the illegal use of controlled substances.
 10. Has been subject to adverse formal action during the course of medical education, postgraduate training, hospital practice, or other medical employment.
 11. Has not practiced medicine and surgery for a period of three (3) years prior to application unless the applicant has been graduated from a school of medicine within that period.
- b) An application filed under Wis. Admin. Code § Med 1.02 shall be reviewed by an Application Review Panel of at least two (2) Board members designated by the Chairperson of the Board. The Panel shall determine whether the applicant is eligible for a regular license without completing an Oral Interview. An applicant can also be required to take an Oral Interview under Wis. Admin. Code § Med 1.08(2) if the applicant has been examined four (4) or more times before achieving a passing grade.

MAILING INSTRUCTIONS:

Mail the Application (Form #2862), the appropriate fee and documentation to the following address:

MAILING ADDRESS:

DSPS
ATTN: MEDICAL EXAMINING BOARD
P.O. BOX 8935
MADISON, WI 53708-8935

EXPRESS DELIVERY:

DSPS
ATTN: MEDICAL EXAMINING BOARD
4822 MADISON YARDS WAY
MADISON, WI 53705

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CODES FOR SPECIALTIES: Enter specialty code(s) on page 1 of the Application.

Academic Medicine	37	Otolaryngology	67
Administrative Medicine	71	Otorhinolaryngology - Ent	15
Aerospace Medicine	33	Pain	66
Alcoholism - Chemical Dependency	49	Pathology	16
Allergy - Immunology	01	Pathology - Clinical	17
Anesthesiology	02	Pathology - Surgical Anatomic	72
Aviation Medicine	32	Pediatrics	18
Dermatology	03	Pediatrics - Other	60
Emergency Medicine	31	Perinatology	62
Endocrinology	56	Pharmacology - Clinical	48
Family Practice	41	Physical Medicine and Rehabilitation	19
Gastroenterology	06	Preventive Medicine	09
General Practice	08	Proctology	36
Genetics	61	Psychiatry	20
Geriatrics	29	Psychiatry - Child	21
Hand Surgery	64	Public Health	22
Hebiatrics	46	Radiation - Oncology	70
Hematology	07	Radiology	53
Hyperbaric Medicine	65	Radiology - Diagnostic	43
Immunology - Infectious Diseases	47	Radiology - Nuclear Medicine	68
Institutional Medicine	39	Radiology - Ultrasound	69
Internal Medicine	04	Research	34
Internal Medicine - Cardiology	05	Retired	24
Internal Medicine - Pulmonary Medicine	45	Rheumatology	57
Neonatology	63	School Physician	52
Nephrology	40	Surgery - Cardiovascular	44
Neurology	10	Surgery - Colon and Rectal	54
Neurophysiology	51	Surgery - General	25
Nuclear Medicine	23	Surgery - Maxillofacial	58
Obstetrics and Gynecology	12	Surgery - Neurological	11
Occupational Medicine	30	Surgery - Peripheral Vascular	59
Oncology	38	Surgery - Plastic	26
Ophthalmology	13	Surgery - Thoracic	27
Orthopedic Surgery	14	Urology	28

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MEDICAL EXAMINING BOARD

APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY FOR INDIVIDUALS WITH A CURRENT UNRESTRICTED MINNESOTA LICENSE

(This application does not apply for individuals who hold a Minnesota Telemedicine license.)

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, phone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>
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Address (street, city, state, zip code) <input type="text"/>	Daytime Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/>
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Mailing Address (if different) <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
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Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.
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Ethnicity/gender status information is optional.

Ethnicity: White, not of Hispanic origin American Indian or Alaskan Hispanic
 Black, not of Hispanic origin Asian or Pacific Islander Other

Sex: M F

Have you ever been licensed in Wisconsin as a Physician? Yes No **If yes, list your credential number:** _____

If WI license has been expired more than 5 years, **submit [Form 570](#)** (not this form, #2862). If WI license expired less than 5 years, see renewal information at <https://dsp.wi.gov/Pages/Professions/Physician/Default.aspx>.

E-mail Address

Medical School Name <input type="text"/>	Medical School Address (street, city, state) <input type="text"/>
Date Degree Granted <input type="text"/> / <input type="text"/> / <input type="text"/>	Degree <input type="text"/>
Specialty (see page iii for a listing of codes) <input type="text"/>	Specialty Code <input type="text"/>

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

For Receiving Use Only (20/21)

- I am seeking a Veteran Fee Waiver** (for Initial Credential Fee only, see page 2 for further information)
- Reciprocity of MN State Board**
\$ 75.00 Reciprocal Initial Credential Fee
\$ 75.00 Total Fee Attached

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- Authorization and Waiver (**Form#571**)
- Convictions and Pending Charges (**Form #2252**), if applicable
- Malpractice Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, if applicable
- Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc.

ARE YOU A VETERAN? If yes, please view the Department website at <https://dsps.wi.gov/Pages/Professions/MilitaryLicensureBenefits.aspx> for information and eligibility requirements for veterans, service members, former service members, and their spouses.

If you qualify, are you requesting a waiver of your initial credentialing fee? Yes No

If Yes, provide a copy of your Department of Veterans Affairs voucher code and list your DVA Voucher Code Number: _____

If you qualify, are you requesting equivalency of your military training and experience? Yes No

If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

(You may contact the WDVA at 1-800-947-8387 or dva.wi.gov for assistance in obtaining your WDVA Voucher Code and/or documents related to your training.)

If you qualify, are you a service member, former service member, or spouse requesting a reciprocal credential? Yes No

If Yes, **do not complete this form**. You must complete and return the Reciprocal Credential Application for Service Members, Former Service Members, and Their Spouses (**Form #3982**).

CONTINUING EDUCATION AND RENEWAL REQUIREMENTS: Please view the Department website at <http://dsps.wi.gov> and select "Professions," then "Physician."

POST-GRADUATE TRAINING: Account for all post-graduate training activities. All facilities listed below must complete (**Form #2165**) and return directly to the Department to certify your completion of training. (Attach additional sheets, if necessary.)

Dates (Month/Year)	Type	Name of School, Hospital Clinic, or Other	Location (City, State and Country)
(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/> Post-Grad <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow		(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/> (Country) <input style="width: 100%; height: 20px;" type="text"/>
(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/> Post-Grad <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow		(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/> (Country) <input style="width: 100%; height: 20px;" type="text"/>
(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>	<input type="checkbox"/> Post-Grad <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow		(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/> (Country) <input style="width: 100%; height: 20px;" type="text"/>

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ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

1.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases? (See https://docs.legis.wisconsin.gov/code/admin_code/dhs/110/145 and https://docs.legis.wisconsin.gov/statutes/statutes/252 .)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license, or other credential in Wisconsin, or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever failed to pass any state board examination, national board (NBME or NBOME), FLEX, or, USMLE examination? If yes, provide details below: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor, or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	If yes to question 6 above, did you apply for a predetermination of the conviction(s)? If yes, proceed to question 8. If no, submit Convictions and Pending Charges Form #2252 and supporting documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	If yes to question 7, did you receive a letter indicating the conviction(s) did not disqualify you from licensure? If yes, proceed to question 9. If no, submit Convictions and Pending Charges Form #2252 and supporting documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	If yes to question 8, since the date of the letter indicating you were not disqualified from licensure, have you been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor, or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. If yes, submit Convictions and Pending Charges Form #2252 and supporting documentation for each conviction and pending charge since the date of the letter. If no, submit Convictions and Pending Charges Form #2252 without previously submitted documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Are you incarcerated, on probation, or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition and complete Malpractice Suits or Claims (Form #2829).	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Have your hospital privileges ever been limited or removed? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

Wisconsin Department of Safety and Professional Services

"Ability to practice medicine" is to be construed to include all of the following: *(continued from previous page)*

3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"**Medical Condition**" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"**Chemical Substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"**Currently**" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years**.

"**Illegal use of Controlled Dangerous Substances**" means the use of controlled dangerous substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner.

ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

16.	Do you have a medical condition, which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If no, you may skip questions 17 and 18. If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	Are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
21.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22.	If yes to question 21, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No

CERTIFICATION OF LEGAL STATUS

I declare under penalty of law that I am (check one):

- A citizen or national of the United States, or
- A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at <http://www.uscis.gov>.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect, or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of 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. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I have provided to the Department of Safety and Professional Services change.

Signature: Date: / /