Wisconsin Department of Safety and Professional Services

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Madison, WI 53705
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Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

JOINT COMMISSION CERTIFIED HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

APPLICANT: Complete this section and submit to all hospitals, facilities, and employers where you have had staff privileges, employment, or appointment during the last five (5) years. Form must be returned directly from the Hospital/Facility/Employer to the Department.

Applicant Name:	**Application Number:**

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. I hereby authorize the school named below to provide the Department with the information requested below.

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

HOSPITAL/FACILITY/EMPLOYER: The **State of Wisconsin** requests Joint Commission Certified employers to complete this form for all hospitals, facilities, and where the below physician currently has or previously held staff privileges, or employment during the last five (5) years. **You must answer all of the following questions and provide any additional information in order for this form to be considered complete.** Complete the form for the 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.)

PHYSICIAN'S NAME:

NAME/LOCATION OF FACILITIES: Please attach a complete list of all facilities where the above physician has had employment or staff privileges under your employment. List should include the name of the facility, location (city/state), and dates employed (mo/yr-start/end). The list should be given in alphabetical order.

JOINT COMMISSION CERTIFIED EMPLOYER NAME:

JOINT COMMISSION CERTIFIED EMPLOYER ADDRESS (street/number, city, state, zip code):

JOINT COMMISSION CERTIFIED EMPLOYER TELEPHONE NUMBER:

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JOINT COMMISSION CERTIFIED EMPLOYER ORGANIZATION NUMBER: Submit your number below.	
JOINT COMMISSION CERTIFIED EMPLOYER EMAIL ADDRESS: Submit your email address in the spaces below.	
1. Has your entity received Joint Commission Certified certification?	☐ **Yes** ☐ **No**

2. What position does the physician hold under your employment? _____

3. List the physician's dates of employment or staff privileges under your employment:

   From _____/_____/_____ **To** _____/_____/_____

4.	Did the physician either leave your employment in good standing or is currently employed and in good standing? **If no, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
5.	Was the physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment**? If yes, please provide explanation on a separate sheet and attach to this form.**	☐ **Yes** ☐ **No**
6.	Was the physician granted a leave of absence while employed at any of your facilities or under your employment? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
7.	Did this individual have a record of unexcused absences during his/her attendance at any of your facilities or under your employment? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
8.	Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees or staff holding similar positions? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
9.	Were any restrictions placed on this physician's privileges? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
10.	Were any formal patient or staff complaints filed against this physician**? If yes, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
11.	Was the physician denied hospital privileges while employed by you? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
12.	Were any incident reports filed involving the professional conduct or behavior of the physician**? If yes, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
13.	Was the physician ever subject to non-routine monitoring while at your facility? **If yes, please attach explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
14.	Was the physician involuntarily removed from a call schedule for cause**? If yes, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
15.	Was the physician subject to non-routine quality assessment review? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**
16.	Was the physician the subject of a negative review by a quality assurance or departmental committee**? If yes, please provide explanation on a separate sheet and attach to this form**.	☐ **Yes** ☐ **No**

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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.	
Signature, Joint Commission Certified Employer/Official Supplying Information: (If unable to provide a digital signature, please print and sign form.)	**Date:**
	_____/_____/_____
Printed Name:	**Phone:**
Title, Joint Commission Certified Employer/Official Supplying Information:	