

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

Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dspd@wisconsin.gov
Website: <http://dspd.wi.gov>

DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

LICENSE TRANSITION ADDENDUM

Complete the appropriate section (A or B) below and return this Form (#3047) directly to DSPS. You may fax/email to: (608) 251-3036 or DSPSCREDMEDBD@wisconsin.gov. Please allow 10-15 business days for this request to be reviewed and processed.

PLEASE TYPE OR PRINT IN INK			
<input type="checkbox"/> Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)			
License Holder Last Name	First Name	MI	Former / Maiden Name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Wisconsin License #: <input type="text"/>			
Type of License: (check one): <input type="checkbox"/> MD <input type="checkbox"/> DO			
Section A: This section applies to individuals who currently hold a <u>Physician credential</u> , and are requesting the credential transition to an Administrative Physician credential. Please read carefully and sign/date below. <input type="checkbox"/> I understand that per Wis. Admin. Code Med 23.04, I may no longer examine, care for, or treat patients. I no longer have the authority to prescribe drugs or controlled substances, delegate medical acts, issue opinions regarding medical necessity or conduct clinical trials on humans. <input type="checkbox"/> I understand that my current license will expire and I will be issued a new license upon completion of my license transition. <input type="checkbox"/> I understand that the grant date of the Administrative Physician license will be the same as the grant date of my original Physician license. <input type="checkbox"/> I understand that I am subject to all Wisconsin laws and rules regarding Administrative Physicians.			
Signature: <input type="text"/>		Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Section B: This section applies to individuals who currently hold an Administrative Physician credential and are requesting the credential transition to a Physician credential. Please read carefully and sign/date below. <input type="checkbox"/> I understand that the Medical Examining Board will review my petition to return to active practice and may request additional information or an appearance before the Board to determine eligibility. <input type="checkbox"/> I understand that the current license will expire and I will be issued a new license upon completion of my license transition. <input type="checkbox"/> I understand that the grant date of the Physician license will be the same as the grant date of my Administrative Physician license. <input type="checkbox"/> I understand that the restrictions per Wis. Admin. Code Med 23.04 remains in effect until the time that my license has transitioned. <input type="checkbox"/> I understand that I am subject to all Wisconsin laws and rules regarding Physicians. <input type="checkbox"/> My last date of active practice was <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Signature: <input type="text"/>		Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	