Wisconsin Department of Safety and Professional Services

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DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

LICENSE TRANSITION ADDENDUM

Complete the appropriate section (A or B) below and return this Form (#3074) 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 PRINT IN INK ☐ Your name, address, phone number, and e-mail address are available to the public. Check box to withhold street address/PO Box, phone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

License Holder Last Name	First Name	MI	Former / Maiden Name(s)

Wisconsin License #:

Type of License: (check one): ☐ MD ☐ DO

SECTION A: This section applies to an individual who currently holds a Physician credential and is submitting a request to transition the credential to an Administrative Physician credential.

Please read carefully and sign/date below.

☐ 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.

☐ I understand that my current license will expire, and I will be issued a new license upon completion of my license transition.

☐ I understand that the grant date of the Administrative Physician license will be the same as the grant date of my original Physician license.

☐ I understand that I am subject to all Wisconsin laws and rules regarding Administrative Physicians.

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

SECTION B: This section applies to an individual who currently holds an Administrative Physician credential and is requesting to transition the credential to a Physician credential.

Please read carefully and sign/date below.

☐ 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.

☐ I understand that the current license will expire, and I will be issued a new license upon completion of my license transition.

☐ I understand that the grant date of the Physician license will be the same as the grant date of my Administrative Physician license.

☐ I understand that the restrictions per Wis. Admin. Code § Med 23.04 remain in effect until the time that my license has transitioned.

☐ I understand that I am subject to all Wisconsin laws and rules regarding Physicians.

☐ My last date of active practice was __/__/____.

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