Wisconsin Department of Safety and Professional Services

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MEDICAL EXAMINING BOARD

HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

Interstate Medical Licensure Compact (IMLC)

APPLICANT: Please forward this form to all hospitals, facilities, and employers in the state of Wisconsin where 25% of your practice occurs. Form must be returned directly from the hospital, facility, or employer to the Department.

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

Application Number	Phone Number	Email Address

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 (Provide a digital signature or print and sign form.)	**Date**
	_____/ _____/ _____

HOSPITAL/FACILITY/EMPLOYER: The Medical Examining Board requests that you complete this form concerning the above-named individual. Complete this section and return the form directly to the Department by emailing it to IMLCompact@wi.gov. You must answer all of the following questions and provide any additional information in order for this form to be considered complete.

Name of Hospital/Facility/Employer	Hospital/Facility/Employer Daytime Phone

Address (number/street)	(city)	(state)	(zip code)

1. What position does this Physician hold at your facility or under your employment?

2. How often does this physician practice at your facility or provide services to patients located in Wisconsin (i.e., telemedicine)?

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 (Provide a digital signature or print and sign form.)	**Date**
	_____/ _____/ _____
Printed Name	**Phone**

Title