Wisconsin Department of Safety and Professional Services

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MEDICAL EXAMINING BOARD

HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION (IMLC)

APPLICANT: Please forward this form to all hospitals, facilities, and employers in the State of Wisconsin where 25% of your practice occurs.

HOSPITAL/FACILITY/EMPLOYER: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name: _____

Name of Hospital/Facility/Employer: _____

Hospital/Facility/Employer's Address: _____

Hospital/Facility/Employer's Daytime Phone: ___ - ___ - ____

Hospital/Facility/Employer, you must answer all of the following questions and provide any additional information in order for this form to be considered complete.

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)?

_____

Name/Title of Individual Supplying Information:

_____

Signature: _____ Date __/__/__

(Print and Sign Form)

Hospital/Facility/Employer, please email with facility coversheet/letter and return directly to:
DSPSCredMedBD@wisconsin.gov**.**