Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
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Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

PODIATRY AFFILIATED CREDENTIALING BOARD

TEMPORARY EDUCATIONAL LICENSE - AFFIDAVIT OF HOSPITAL AUTHORITY

The President/Dean or a delegate of the President/Dean of the training program must complete this form if the applicant has been or will be accepted into a post-graduate training program accredited by the ACGME/AOA.

Applicant Name: _____

Name of Hospital: _____

Address of Hospital: _____

The above listed applicant has made application for post-graduate training in this Hospital under the provision of a Temporary Educational License, which will entitle him/her to receive training under the direction of a licensed Wisconsin podiatrist for a period not to exceed one (1) year.

I have examined the credentials of the applicant listed above and find that he/she meets the requirements of the Podiatry Affiliated Credentialing Board regulations governing these licenses, and are satisfactory to this Hospital. I hereby recommend that the Board consider this application for a Temporary Educational License, with his/her post-graduate training to begin as stated below.

Start Date of Training: __/__/__

Printed Name of licensed Wisconsin Podiatrist: _____

Signature of licensed Wisconsin Podiatrist:
(Print and Sign Form) _____

Wisconsin Podiatric Surgery License Number: _____

Date signed __/__/__

Hospital/Facility, please return directly to:

DSPS
Attn: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Or you may fax/email with facility cover sheet/letter to: (608) 251-3036 or DSPSCredMedBD@wisconsin.gov**.**

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