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: dsps@wisconsin.gov
Website: http://dsps.wi.gov

PHYSICAL THERAPY EXAMINING BOARD

INFORMATION FOR COMPLETING APPLICATION FOR A LOCUM TENENS LICENSE TO PRACTICE PHYSICAL THERAPY

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- Application (**Form #563**) and appropriate fee
- Copy of **a current registration card** to practice physical therapy in another jurisdiction of the United States or Canada.
- A letter from the employer requesting the applicant's services, received directly from the hiring facility.
- A letter of recommendation from a physician, supervisor, or present employer stating the applicant's professional capabilities.
- Wisconsin Statutes and Rules Examination
- Convictions and Pending Charges (**Form #2252**), if applicable
- Malpractice Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, if applicable
- Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc.

Oral Examination Candidates:

Exam and endorsement applicants **may** be required to complete an oral examination if he/she:

1. has a medical condition which in any way impairs or limits the applicant's ability to practice physical therapy with reasonable skill and safety;
2. uses chemical substances so as to impair in any way the applicant's ability to practice physical therapy with reasonable skill and safety;
3. have been diagnosed as suffering from pedophilia, exhibitionism or voyeurism;
4. has within the past two (2) years engaged in the illegal use of controlled dangerous substances;
5. has been subject to adverse formal action during the course of physical therapy education, postgraduate training, hospital practice, or other physical therapy employment;
6. has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction;
7. has been convicted of a crime the circumstances of which substantially relate to the practice of physical therapy;
8. has not practiced physical therapy for a period of three (3) years prior to application, unless the applicant has been graduated from a school of physical therapy within that period;
9. has been graduated from a physical therapy school not approved by the Board.

An applicant who meets any of the above criteria, #1-9 will be reviewed by the Physical Therapists Affiliated Credentialing Board members. The Board shall determine whether the applicant is eligible for a regular license without completing an oral examination.

All examinations shall be conducted in the English language. Where both written and oral examinations are required, they shall be scored separately and the applicant is required to achieve a passing grade on both examinations to qualify for a license.
If you are selected to appear for an oral examination, you will be advised of the date upon completion of your application.

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APPLICATION FOR A LOCUM TENENS LICENSE TO PRACTICE PHYSICAL THERAPY

Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stats. § 440.12).

PLEASE TYPE OR PRINT IN INK ☐ 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).

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

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __ __ / __ __ / ____

Social Security # ___ - ___ - ____

Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Ethnicity/gender status information is optional.

Ethnicity: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Hispanic ☐ Other

Sex: ☐ M ☐ F

Have you ever been licensed in Wisconsin as a Physical Therapist? ☐ Yes ☐ No If yes, list your credential number:

Email Address

Beginning Date of Practice in Wisconsin __ __ / __ __ / ____

Facility Name and Address

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

☐ **I am seeking a Veteran Fee Waiver** (for Initial Credential Fee only, see page 2 for further information)

☐ **Initial Credential**
$ 68.00 Initial Credential Fee
$ 75.00 State Law Exam
$ 143.00 Total Fee Attached

For Receipting Use Only (875)

Committed to Equal Opportunity in Employment and Licensing

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ARE YOU A VETERAN? If yes, please view the Department website at http://dsps.wi.gov under "License, Permits, and Registrations" and select "Military Benefits Related to Licensure for Eligible Veterans Services Members and Spouses" for eligibility requirements.

If you qualify, are you requesting a waiver of your initial credentialing fee? ☐ Yes ☐ No

If Yes, provide a copy of your Department of Veterans Affairs voucher code and list your DVA Voucher Code Number:

If you qualify, are you requesting equivalency of your Military Training and experience? ☐ Yes ☐ No
If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

If you qualify, are you requesting Temporary Spousal Reciprocal License? ☐ Yes ☐ No

If Yes, do not complete this form. You must complete and return the Application for Temporary Spousal Reciprocal License (**Form #2982**).
You may contact the DVA at 1-800-WisVets or www.WISVET.com for assistance in obtaining your DVA Voucher Code and/or documents related to your training.

I AM OR HAVE BEEN LICENSED IN THE FOLLOWING STATE(S): (include all active and inactive states)

For each credential listed above, you are required to have each State Board or territory of the United States submit a letter of verification to the Wisconsin Physical Therapy Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

PROFESSIONAL EDUCATION:

School Name

School Address (city, state)

Date Degree Granted / /

Degree

PRACTICE: Account for all activities and practice starting from the date of graduation from physical therapy school to the present time. Must include professional and nonprofessional activities. All time and dates must be accounted for. (Attach additional sheets, if necessary.)

Employer Name	**Location of Employment** (City/State)	**Dates Employed** (Month/Year)	**The Capacity in Which You Are/Were Employed**
	(City) (State)	(From) / (To) /	
	(City) (State)	(From) / (To) /	
	(City) (State)	(From) / (To) /	

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ANSWER THE FOLLOWING QUESTIONS (attach additional sheet(s) if necessary)

1.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases?	☐ Yes ☐ No
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	☐ Yes ☐ No
3.	Have you ever failed to pass any state board examination, national board examination, NPTE examination? **If yes, provide details below:**	☐ Yes ☐ No
4.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? **If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.**	☐ Yes ☐ No
5.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	☐ Yes ☐ No
6.	Have you ever been convicted of a misdemeanor or a felony, or do you have any felony or misdemeanor charges pending against you? **If yes, submit Convictions and Pending Charges (Form #2252).**	☐ Yes ☐ No
7.	Are you incarcerated, on probation, or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	☐ Yes ☐ No
8.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition and complete Malpractice Suits or Claims (Form #2829).**	☐ Yes ☐ No
9.	Have your privileges ever been limited or removed? **If yes, please explain.**	☐ Yes ☐ No
10.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):**	☐ Yes ☐ No
11.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under:**	☐ Yes ☐ No

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice physical therapy" is to be construed to include all of the following:
1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned physical therapy judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform physical therapy tasks such as examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, Cerebral Palsy, epilepsy, Muscular Dystrophy, Multiple Sclerosis, cancer, heart disease, Diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of Controlled Dangerous Substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner.

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ANSWER THE FOLLOWING QUESTIONS (attach additional sheet(s) if necessary)

12.	Do you have a medical condition, which in any way impairs or limits your ability to practice physical therapy with reasonable skill and safety? **If yes, please explain**.	☐ Yes ☐ No
13.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice physical therapy with reasonable skill and safety? **If yes, please explain**.	☐ Yes ☐ No
14.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? **If yes, please explain**.	☐ Yes ☐ No
15.	Are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If yes, please explain**.	☐ Yes ☐ No
16.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **If yes, please explain**.	☐ Yes ☐ No
17.	Are you currently engaged in the illegal use of controlled dangerous substances?	☐ Yes ☐ No
18.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain**.	☐ Yes ☐ No

CERTIFICATION OF LEGAL STATUS:

I declare under penalty of law that I am (check one):

☐ A citizen or national of the United States, or

☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of 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. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature: _____ Date: __ __ / __ __ / __ __ __ __