

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

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

MEDICAL EXAMINING BOARD

INFORMATION FOR COMPLETING THE APPLICATION FOR A RESIDENT EDUCATIONAL LICENSE

PLEASE PLAN AHEAD:

Applicants, recruiters, institutions, and others involved in the placement of individuals who seek to be credentialed in the state of Wisconsin should understand that the credentialing process takes time and that credentialing is not guaranteed to any applicant. Factors that determine the length of time it may take to process an application include the length of time the applicant has been in practice, the total number of jurisdictions in which the applicant has been credentialed, and the length of time it takes for supporting documents to be received in the Board office and reviewed.

The application consists of an all-inclusive packet with instructions and information on all applicable requirements. We strive to process applications in a timely fashion. We cannot issue a credential until all of the required documents have been received and reviewed in the Board office.

It is the Department's mission and legislative mandate to provide consumer protection for Wisconsin residents. The Department and the Board have been asked to waive requirements to expedite the process, only to discover legitimate grounds to deny a credential. This can present a serious problem for the applicant, recruiter, or institutions if the applicant has relocated, purchased property, or made other commitments prior to the issuance of a Wisconsin credential. **We urge you not to make these moves until you know that your credential has been issued.** Please "plan ahead" as we cannot speed up the credentialing process or waive supporting documents even in emergency situations.

This license is designed for an applicant who has been accepted into a post-graduate training program in a facility in this state approved by the Board under the provisions in [Wis. Admin. Code § Med 5.02](#).

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

- Completed application form and fee ([Form #564](#))
- Certificate of Professional Education ([Form #3050](#))
- Affidavit of Hospital Authority ([Form #2601](#))

MAILING INSTRUCTIONS: Mail the Application for Licensure, the appropriate fee, and documentation to the following address:

MAILING ADDRESS:

DSPS
ATTN: MEDICAL EXAMINING BOARD
P.O. BOX 8935
MADISON WI 53708-8935

EXPRESS DELIVERY:

DSPS
ATTN: MEDICAL EXAMINING BOARD
4822 MADISON YARDS WAY
MADISON WI 53705

Wisconsin Department of Safety and Professional Services

CODES FOR SPECIALTIES: Enter specialty code(s) on page 1 of the Application.

Academic Medicine	37	Otolaryngology	67
Administrative Medicine	71	Otorhinolaryngology - ENT	15
Aerospace Medicine	33	Pain	66
Alcoholism - Chemical Dependency	49	Pathology	16
Allergy - Immunology	01	Pathology - Clinical	17
Anesthesiology	02	Pathology - Surgical Anatomic	72
Aviation Medicine	32	Pediatrics	18
Dermatology	03	Pediatrics - Other	60
Emergency Medicine	31	Perinatology	62
Endocrinology	56	Pharmacology - Clinical	48
Family Medicine	925	Physical Medicine and Rehabilitation	19
Gastroenterology	06	Preventive Medicine	09
General Practice	08	Proctology	36
Genetics	61	Psychiatry	20
Geriatrics	29	Psychiatry - Child	21
Hand Surgery	64	Public Health	22
Hebiatrics	46	Radiation - Oncology	70
Hematology	07	Radiology	53
Hyperbaric Medicine	65	Radiology - Diagnostic	43
Immunology - Infectious Diseases	47	Radiology - Nuclear Medicine	68
Institutional Medicine	39	Radiology - Ultrasound	69
Internal Medicine	04	Radiology - Interventional	946
Internal Medicine - Cardiology	05	Research	34
Internal Medicine - Pulmonary Medicine	45	Retired	24
Neonatology	63	Rheumatology	57
Nephrology	40	School Physician	52
Neurology	10	Surgery - Cardiovascular	44
Neuromuscular Medicine	926	Surgery - Colon and Rectal	54
Neurophysiology	51	Surgery - General	25
Nuclear Medicine	23	Surgery - Maxillofacial	58
Obstetrics and Gynecology	12	Surgery - Neurological	11
Occupational Medicine	30	Surgery - Peripheral Vascular	59
Oncology	38	Surgery - Plastic	26
Ophthalmology	13	Surgery - Thoracic	27
Orthopedic Surgery	14	Urology	28

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APPLICATION FOR RESIDENT EDUCATIONAL LICENSE

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK Your name, address, telephone number, and e-mail address are available to the public. Check box to withhold address, telephone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>
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Address (street, city, state, zip code) <input type="text"/>	Daytime Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/>
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Mailing Address (if different) <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
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Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>	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.
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Ethnicity/gender status information is optional.

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

Sex: M F

E-mail Address

Specialty (See page ii for a listing of codes.) <input type="text"/>	Specialty Code (See page ii for a listing of codes.) <input type="text"/>
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Medical School <input type="text"/>	Medical School Address (street, city, state) <input type="text"/>
Degree <input type="text"/>	Date Degree Granted <input type="text"/> / <input type="text"/> / <input type="text"/>

APPLICATION FEES: Make check payable to DSPS and attach to this application or fax application with [Form 3071](#), Fax Payment Form.

Required DSPS Fee: \$10.00

For Receiving Use Only (851)

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POST-GRADUATE TRAINING/FELLOWSHIPS, PRACTICE, AND OTHER ACTIVITIES: List in chronological order from the date of graduation of medical school to the present time. The information provided below **must include professional and nonprofessional activities** to ensure there are no gaps in time from the time of medical school graduation to the present time. (Attach additional sheets, if necessary, using the same format.)

DATES (Month, Year)	TYPE	NAME OF SCHOOL, HOSPITAL CLINIC OR OTHER	LOCATION (City, State and Country)
From: <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Post Grad <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Practice <input type="checkbox"/> Other		(City) <input type="text"/> (State) <input type="text"/> (Country) <input type="text"/>
From: <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Post Grad <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Practice <input type="checkbox"/> Other		(City) <input type="text"/> (State) <input type="text"/> (Country) <input type="text"/>
From: <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Post Grad <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Practice <input type="checkbox"/> Other		(City) <input type="text"/> (State) <input type="text"/> (Country) <input type="text"/>
From: <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Post Grad <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Practice <input type="checkbox"/> Other		(City) <input type="text"/> (State) <input type="text"/> (Country) <input type="text"/>
From: <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Post Grad <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Practice <input type="checkbox"/> Other		(City) <input type="text"/> (State) <input type="text"/> (Country) <input type="text"/>

ECFMG Exam Taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	Certificate Issued? <input type="checkbox"/> Yes <input type="checkbox"/> No
Certificate #: <input style="width: 80%;" type="text"/>	Date Issued: <input type="text"/> / <input type="text"/> / <input type="text"/>

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

1.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases? https://docs.legis.wisconsin.gov/code/admin_code/dhs/110/145 https://docs.legis.wisconsin.gov/statutes/statutes/252	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
3.	Have you ever failed to pass any State Board, National Board (NBME or NBOME), FLEX, or USMLE Examination? If yes, provide details below: <input style="width: 95%; height: 20px;" type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
6.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor, or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
8.	If yes to question 6 above, did you apply for a predetermination of the conviction(s)? If yes, proceed to question 9. If no, submit Convictions and Pending Charges Form #2252 and supporting documentation.	Yes <input type="checkbox"/> No <input type="checkbox"/>
9.	If yes to question 8, did you receive a letter indicating the conviction(s) and pending charge(s) did not disqualify you from licensure? If yes, proceed to question 10. If no, submit Convictions and Pending Charges Form #2252 and supporting documentation.	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.	If yes to question 9, since the date of the letter indicating you were not disqualified from licensure, have you been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor, or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. If yes, submit Convictions and Pending Charges Form #2252 and supporting documentation for each conviction and pending charge since the date of the letter. If no, submit Convictions and Pending Charges Form #2252 without previously submitted documentation.	Yes <input type="checkbox"/> No <input type="checkbox"/>
11.	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 <input type="checkbox"/> No <input type="checkbox"/>
12.	Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet.	Yes <input type="checkbox"/> No <input type="checkbox"/>
13.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	Yes <input type="checkbox"/> No <input type="checkbox"/>
14.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	Yes <input type="checkbox"/> No <input type="checkbox"/>
15.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical 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 medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

(Continued on next page.)

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"Ability to practice medicine" is to be construed to include all of the following: **(Continued from previous page.)**

"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, intellectual disability, 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.

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary)

16.	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	Yes <input type="checkbox"/> No <input type="checkbox"/>
17.	Does your use of chemical substances in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	Yes <input type="checkbox"/> No <input type="checkbox"/>
18.	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 <input type="checkbox"/> No <input type="checkbox"/>
19.	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 <input type="checkbox"/> No <input type="checkbox"/>
20.	Have you ever been diagnosed as having or have you ever been treated for Pedophilia, Exhibitionism, or Voyeurism? If yes, please explain.	Yes <input type="checkbox"/> No <input type="checkbox"/>
21.	Are you currently engaged in the illegal use of controlled dangerous substances?	Yes <input type="checkbox"/> No <input type="checkbox"/>
22.	If yes to question 21, 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 <input type="checkbox"/> No <input type="checkbox"/>

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 have provided to the Department of Safety and Professional Services change.

Applicant Signature: _____ Date: ____/____/____

(Print and Sign Form)