

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: dspd@wisconsin.gov
Website: <http://dspd.wi.gov>

MEDICAL EXAMINING BOARD

INFORMATION FOR COMPLETING MEDICINE AND SURGERY APPLICATION FORM

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.

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS):

The Department accepts the physician information profile completed by FCVS through the Federation of State Medical Boards. If you choose to utilize FCVS, you will **not** need to submit DSPS forms to verify the following: Medical School Education (**Form #2164**), Post-Graduate Training (**Form #2165**), reporting of licensure exam scores, Physician Data Center Profile from the Federation of State Medical Boards (**Form #1445**), National Practitioner Data Bank Report, or ECFMG certificate. You may obtain this service online at www.fsmb.org.

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

- DSPS Application (**Form #570**) and fee
- Copy of ECFMG certificate if a Foreign Graduate (**FCVS**), **not applicable for Re-Registration**
- Joint Commission Certified Hospital, Facility, and Employer Verification (**Form #3046**), **if applicable**
- Medical Education Verification (**Form #2164**) (**FCVS**), **not applicable for Re-Registration**
- Certificate of Post-Graduate Training (**Form #2165**) (**FCVS**), **not applicable for Re-Registration**
- National Board, FLEX, State Board, USMLE or LMCC score (**FCVS**), **not applicable for Re-Registration**
- National Practitioner Data Bank Report (**FCVS**)
- Proof of 30 hours of CE completed in the previous biennium (**Re-Registration applicants**)
- Malpractice Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, **if applicable**
- Letters from all State Boards where licensed, **including active and inactive licenses**
- Signed Authorization and Waiver (**Form #571**)
- Physician Profile Data Report from the American Medical Association (AMA), or American Osteopathic Association (AOA)
- Physician Data Center Profile from the Federation of State Medical Boards (**Form #1445**) (**FCVS**)
- Hospital, Facility, and Employer Verification (**Form #2167**)
- Convictions and Pending Charges (**Form #2252**), **if applicable**

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

ENDORSEMENT OF FLEX AND/OR USMLE EXAM SCORES:

Please request an electronic transcript of your USMLE and/or FLEX exam score(s) taken at: <https://usmle.fsmb.org/TranscriptRequests> to be forwarded directly to the Department.

ENDORSEMENT OF NATIONAL BOARDS:

Please request that a copy of your exam score(s) be forwarded directly to Wisconsin Medical Examining Board. Forms are available at www.nbme.org. NBME will forward this information directly to the Department.

ENDORSEMENT OF NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS CERTIFICATION:

Submit your request for an “Endorsement of Certification/Official Transcript” and fee to the National Board of Osteopathic Medical Examiners (NBOME) at www.nbome.org. Transcripts must be sent directly from NBOME to the Department.

ENDORSEMENT OF LMCC: (Must be taken after January 1, 1978)

Direct certification from the Medical Council of Canada (LMCC) is required and must be sent directly from LMCC to the Department.

RECIPROCITY OF ANOTHER STATE BOARD EXAM TAKEN PRIOR TO 1972:

Scores must be certified by the State Board where taken and sent directly to the Department. The State Board submitting the information must include all the subjects covered in the examination, scores received, general average, date of the examination, license number, date of issuance, status of licensure, and any information pertaining to disciplinary action.

VERIFICATION OF OTHER MEDICAL LICENSES:

You are required to have each State Board in which you have ever been licensed submit letters of verification to the Department. The letters must indicate your date of birth, license number, date of issuance, and a statement regarding disciplinary actions. These letters will be required in order to complete your application for licensure. Verifications can be submitted directly to the Department via email to DSPSCredMedBd@wisconsin.gov.

NATIONAL PRACTITIONER DATA BANK:

All candidates must request the “Practitioner Request for Information Disclosure” (Self-Query) from the National Practitioners Data Bank. Self-Queries (NPDB) can be found at <http://www.npdb.hrsa.gov>.

Select the option that reads “Self-Query.” After the NPDB has completed your request, they will send the Self-Query response directly to you. Once received, you will need to forward a copy of the response to the Department. This report may be emailed to DSPSCredMedBd@wisconsin.gov or faxed to (608) 251-3036. If you have further questions regarding this report, contact the NPDB helpline at (800) 767-6732.

PHYSICIAN PROFILE DATA REPORT FROM AMA OR AOA:

All MD’s applying for licensure must complete the Physician Profile Data Report. This request can be made from the following website: <https://profiles.ama-assn.org/amaprofiles>.

All DO’s applying for licensure must use the AOA website at www.AOAProfiles.org.

Wisconsin Department of Safety and Professional Services

ORAL EXAMS:

The oral exam process in the State of Wisconsin was created under Wis. Admin. Code § MED 1.06(1). **If you are selected to appear for an oral exam**, you will be scheduled to appear before the Review Panel at one of the regularly scheduled Board meetings. If you are selected for an oral examination, the additional oral examination fee of \$266.00 will be required prior to being scheduled for this exam.

FOREIGN GRADUATES:

- **ECFMG Certificate:** Graduates of foreign medical schools must provide a copy of an ECFMG certificate with “valid indefinitely” status.
- **Fifth Pathway Certificate:** If you participated, you must submit a copy of your Fifth Pathway certificate from the program you attended.

VISITING PHYSICIAN:

This license is designed for a graduate of a medical school, or an osteopathic college approved by the Board, who is invited to serve on the academic staff of a medical school in this state as a Visiting Physician.

A Visiting Physician Application process is almost identical in processing time and of the documentation required as a permanent license, with the following additional requirement. A signed letter from the President or Dean of a medical school, facility, or college in Wisconsin indicating that the applicant intends to teach, research, or practice medicine and surgery at a medical education facility, medical research facility, or medical college in this State as a Visiting Physician.

After your completed application is received by the Department, it will be reviewed by two (2) Members of the Board. Upon approval, you will be issued a Visiting Physician License, valid for one (1) year and remaining valid only while the license holder is actively engaged in teaching, researching, or practicing medicine and surgery, and is lawfully entitled to work in the United States. This may be renewed at the discretion of the Board.

The holder of a Visiting Physician license may practice medicine and surgery providing such practice is entirely limited to the medical education facility, medical research facility, or the medical college where the license holder is teaching, researching, or practicing medicine and surgery, and only within the terms and restrictions established by the Board.

ADMINISTRATIVE PHYSICIAN:

This license is designed for an applicant whose primary responsibilities are those of an administrative or academic nature.

The holder of an Administrative Physician license may not examine, care for, or treat patients. An Administrative Physician license does not include the authority to prescribe drugs or controlled substances, delegate medical acts, issue opinions regarding medical necessity, or conduct clinical trials on humans.

Applicants for an Administrative Physician license must also meet the same qualifications for licensure as applicants applying under Wis. Stat. § 448.05 (2)(a) or (b).

Wisconsin Department of Safety and Professional Services

CODES FOR SPECIALTIES:

Enter specialty code(s) on page 1 of the “Application for Licensure to Practice Medicine and Surgery.”

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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MEDICAL EXAMINING BOARD

APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY

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 <input type="checkbox"/> Your name, address, telephone number, and email address are available to the public. Check box to withhold address, telephone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).			
Last Name	First Name	MI	Former / Maiden Name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address (street, city, state, zip)		Daytime Telephone Number	
<input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>	
Mailing Address (if different)		Date of Birth	
<input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>	
Social Security Number	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.		
<input type="text"/> - <input type="text"/> - <input type="text"/>			
Ethnicity/gender status information is optional.			
Ethnicity: <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hispanic <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other			
Sex: <input type="checkbox"/> M <input type="checkbox"/> F			
Have you ever been licensed in Wisconsin as a Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list your credential number:			
<input type="text"/>			
Email Address			
<input type="text"/>			
Specialty (see page iv for a listing of codes)		Specialty Code (see page iv for a listing of codes)	
<input type="text"/>		<input type="text"/>	
Medical School		Medical School Address (street, city, state)	
<input type="text"/>		<input type="text"/>	
Degree	Please check one:	Date Degree Granted	
<input type="text"/>	<input type="checkbox"/> MD <input type="checkbox"/> DO	<input type="text"/> / <input type="text"/> / <input type="text"/>	

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

- | | |
|--|---|
| <input type="checkbox"/> Please check this box if you are applying for Administrative Physician Licensure | <input type="checkbox"/> Endorsement of LMCC (taken after 1/1/78)
\$75.00 Initial Credential Fee
\$75.00 Total Fee Attached |
| <input type="checkbox"/> I am seeking a Veteran Fee Waiver (for Initial Credential Fee only, see page 2 for further information) | <input type="checkbox"/> Reciprocity of State Board Exam (Taken Prior to 1972)
\$75.00 Reciprocal Credential Fee
\$75.00 Total Fee Attached |
| <input type="checkbox"/> Endorsement of Steps 1, 2 and 3 of USMLE
\$75.00 Initial Credential Fee
\$75.00 Total Fee Attached | <input type="checkbox"/> Visiting Physician
\$59.00 Reciprocal Credential Fee
\$59.00 Total Fee Attached |
| <input type="checkbox"/> Endorsement of National Boards (MD or DO), (NBME or NBOME)
\$75.00 Initial Credential Fee
\$75.00 Total Fee Attached | <input type="checkbox"/> Re-Registration (license expired more than 5 years)
\$ 75.00 Renewal Fee
\$ 25.00 Late Renewal Fee
\$100.00 Total Fee Attached |
| <input type="checkbox"/> Endorsement of FLEX
\$75.00 Initial Credential Fee
\$75.00 Total Fee Attached | |

For Receiving Use Only (20/21/220/221/876)

Wisconsin Department of Safety and Professional Services

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

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- Physician Profile Data Report from the American Medical Association or American Osteopathic Association
- Copy of ECFMG Certificate if a Foreign Graduate (**FCVS**), **not applicable for Re-Registration**
- Joint Commission Certified Hospital, Facility, and Employer Verification (**Form #3046**), **if applicable**
- Medical Education Verification Form (**Form #2164**) (**FCVS**), **not applicable for Re-Registration**
- Signed Authorization and Waiver Form (**Form #571**)
- Letters from all State Boards where licensed, **active and inactive**
- National Board, FLEX, State Board, USMLE or LMCC score (**FCVS**), **not applicable for Re-Registration**
- Certificate of Post-graduate Training (**Form #2165**) (**FCVS**), **not applicable for Re-Registration**
- Proof of 30 hours of CE completed in the previous biennium (**Re-Registration applicants**)
- 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**
- Physician Data Center Practitioner Profile Report from the Federation of State Medical Boards (**Form #1445**), (**FCVS**)
- Hospital, Facility and Employer Verification (**Form #2167**)
- Copy of a license to practice medicine and surgery in another state or Canada and a letter of good standing, **only required for Visiting Physician**
- National Practitioner Data Bank Report (**FCVS**)
- Signed Letter from the President or Dean of a medical school, facility, or college in Wisconsin indicating that the applicant intends to teach, research, or practice medicine and surgery at a medical education facility, medical research facility, or medical college in this State as a Visiting Physician, **only required for Visiting Physician**
- Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc.

ARE YOU A VETERAN? If yes, please view the Department website at <https://dsps.wi.gov/Pages/Professions/MilitaryLicensureBenefits.aspx> 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.WISVETS.com for assistance in obtaining your DVA Voucher Code and/or documents related to your training.

CONTINUING EDUCATION AND RENEWAL REQUIREMENTS: Please view the Department website at <https://dsps.wi.gov/Pages/Professions/Physician/Default.aspx>.

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 below information **must include professional and nonprofessional activities**. (**Attach additional sheets if necessary using the same format.**)

For all hospitals, facilities and employers where you are or have been employed, had or held staff privileges or appointments **for five years preceding** the date of application, the Hospital, Facility and Employer Verification form (**Form #2167**) must be submitted.

Please Note: The dates provided on this application must match the dates provided on the verification provided by the facility. Discrepancies will cause delays in the application process.

<u>DATES</u> (Month, Year)	<u>TYPE</u>	<u>NAME OF SCHOOL, HOSPITAL CLINIC OR OTHER</u>	<u>LOCATION</u> (City, State and Country)
(From) <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/> (To) <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/>	<input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Practice <input type="checkbox"/> Other		(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 60%; height: 20px;" type="text"/> (Country) <input style="width: 100%; height: 20px;" type="text"/>
(From) <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/> (To) <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/>	<input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Practice <input type="checkbox"/> Other		(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 60%; height: 20px;" type="text"/> (Country) <input style="width: 100%; height: 20px;" type="text"/>
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Wisconsin Department of Safety and Professional Services

POST-GRADUATE TRAINING/FELLOWSHIPS, PRACTICE, AND OTHER ACTIVITIES, continued. . .

<u>DATES</u> (Month, Year)	<u>TYPE</u>	<u>NAME OF SCHOOL, HOSPITAL CLINIC OR OTHER</u>	<u>LOCATION</u> (City, State and Country)
(From) <input type="text"/> / <input type="text"/> (To) <input type="text"/> / <input type="text"/>	<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"/>
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(From) <input type="text"/> / <input type="text"/> (To) <input type="text"/> / <input type="text"/>	<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"/> 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"/> 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"/>

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

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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 Medical Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS [Attach additional sheet(s) if necessary.]:

1.	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>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	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>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	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	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you ever failed to pass any state board examination, national board examination (NBME or NBOME), FLEX, or USMLE examination? If yes, provide details below: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have you ever been reprimanded, demoted, disciplined, cautioned, placed on probation, limited in your practice or privileges, placed on or taken leave greater than 90 days, or terminated by any employer, educational institution, training program, licensing board, hospital, medical facility, professional society, specialty board, or medical body for any reason? If yes, attach a sheet providing details about the action, including the name of the entity and date of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have any suits or claims ever been filed against you as a result of professional services? If yes, Malpractice Suits or Claims (Form #2829).	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	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. If yes, submit Convictions and Pending Charges (Form #2252).	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	If yes to question 10 above, did you apply for a predetermination of the convictions? If YES, proceed to question 13. If NO, submit Convictions and Pending Charges Form #2252 and supporting documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	If yes to question 12, did you receive an approval letter? If YES, proceed to question 14. If NO, you may proceed to question 15.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	If yes to question 13, since the date of your approval letter 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. If NO, do not submit Convictions and Pending Charges Form #2252.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Wisconsin Department of Safety and Professional Services

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.

"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 direction of a licensed health care practitioner.

ANSWER THE FOLLOWING QUESTIONS [Attach additional sheet(s) if necessary.]:

15.	Do you have a medical, physical, or mental condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If no, you may skip question 16. If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	If yes to question 15, are the limitations or impairments caused by your medical, physical or mental condition reduced or ameliorated because you receive ongoing treatment (with or without medications), participate in a monitoring program or 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Do you use chemical substance(s), as defined above, that in any way impair, or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	Are you currently (within the last two years) engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	If yes to question 18, are you 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

Wisconsin Department of Safety and Professional Services

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: / /