Wisconsin Department of Safety and Professional Services

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Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

AUTHORIZATION AND WAIVER

Applicant: Please complete and forward this form to all sources that verify information directly to the Wisconsin Medical Examining Board (**example: verification of hospital privileges**). Provide a copy of this completed form when submitting your application materials to DSPS.

Last Name: _____

First Name: _____

Middle Initial: _____

Former/Maiden Name(s): _____

Date of Birth (mm/dd/yyyy): ___ / ___ / ____

City/State/Country of Birth: _____

Having filed an application for a license to practice medicine and surgery in the State of Wisconsin, I hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information, which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery, and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

I also authorize and request every person, hospital, clinic, community, governmental agency, court, association, or institution having control of any documents, records, and other information pertaining to me, to furnish to the Wisconsin Medical Examining Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any of its pertinent data and to permit the Wisconsin Medical Examining Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information.

I hereby release, discharge, and exonerate the Wisconsin Medical Examining Board, its agents and representatives, and any person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information, or the investigation made by the Wisconsin Medical Examining Board.

Applicant Signature _____ Date ___ / ___ / ____
(If unable to provide a digital signature, print and sign form.)