Wisconsin Department of Safety and Professional Services

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MEDICAL EXAMINING BOARD

MEDICINE AND SURGERY RENEWAL ADDENDUM FORM

Complete this form in its entirety and submit it to the Department of Safety and Professional Services (DSPS). Incomplete information will delay the processing time.

Wisconsin License Number	Renewal Application Number		
Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**
Email Address			**Daytime Phone Number**
			___ - ___ - ____

Please carefully read the information below as it applies to the questions that follow:

The Medical Examining Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. The purpose of the following questions is to determine the current fitness of the applicant to practice medicine. The following inquiries concern medical, mental health, and substance misuse issues. This information is treated confidentially by the Board to the extent authorized by law. The mere fact of treatment for medical conditions, mental health conditions, or substance misuse is not, in itself, a basis on which an applicant is ordinarily denied licensure when the applicant has demonstrated personal responsibility and maturity in dealing with these issues. The Board encourages applicants who may benefit from such treatment to seek it. The Board may deny a license to an applicant whose ability to function in the practice of medicine or whose behavior, judgment, and understanding is impaired by substance misuse or a medical or mental health condition.

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, 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.

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

1.	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 that has not been previously disclosed? **If no, you may skip Question 2.** **If yes, provide details on an attached sheet and supporting documents, if applicable.**	☐ Yes ☐ No
2.	**If yes to Question 1**, 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), you participate in a monitoring program, or are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If yes, provide details on an attached sheet and supporting documents, if applicable.**	☐ Yes ☐ No
3.	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 that has not been previously disclosed? **If yes, provide details on an attached sheet and supporting documents, if applicable.**	☐ Yes ☐ No
4.	Are you currently (within the last two years) engaged in the illegal use of controlled dangerous substances? **If yes, provide details on an attached sheet and supporting documents, if applicable.** **ALSO, if yes, 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, provide details on an attached sheet and supporting documents, if applicable.**	☐ Yes ☐ No ☐ Yes ☐ No
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism that has not been previously disclosed? **If yes, provide details on an attached sheet and supporting documents, if applicable.**	☐ Yes ☐ No
6.	Have you 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 that has not been previously disclosed? **If yes, attach a sheet providing details about the action, including the name of the entity and date of action and provide supporting documents, if applicable.**	☐ Yes ☐ No
7.	Is disciplinary action pending against you in any jurisdiction that has not been previously disclosed**? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action and provide supporting documents, if applicable.**	☐ Yes ☐ No
8.	Has the Drug Enforcement Administration (DEA) withdrawn your DEA number or warned you, or have you been denied a DEA number that has not been previously disclosed? **If yes, provide details on an attached sheet and supporting documents, if applicable.**	☐ Yes ☐ No
9.	Have there been any medical malpractice claims resulting in payouts made on your behalf that have not been previously disclosed? **If yes, please submit Physician Malpractice Suits or Claims (**Form 12829**) and supporting documents, if applicable.**	☐ Yes ☐ No

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 statement (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.

Signature: _____ **Date:** __/__/____

(Provide a digital signature or print and sign form.)