



**Scott Walker, Governor**  
**Laura Gutiérrez, Secretary**

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**LICENSURE FORMS COMMITTEE  
MEDICAL EXAMINING BOARD  
Room N208, 4822 Madison Yards Way, Madison  
Contact: Tom Ryan (608) 266-2112  
November 14, 2018**

*The following agenda describes the issues that the Committee plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Committee. A quorum of the Board may be present during any committee meetings.*

**AGENDA**

**9:30 A.M.**

*(or immediately following the Medical Examining Board meeting)*

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

- A. Adoption of Agenda (1)**
- B. Administrative Updates**
  - 1. Department and Staff Updates
- C. Review of Application and Renewal Forms (2-40)**
  - 1. **10:30 A.M. APPEARANCE: Joseph Nartowicz and Zachary Hendrickson - Relating to Initial and Renewal Applications and Processes**
- D. Next Steps**
- E. Public Comments**

**ADJOURNMENT**

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held at 4822 Madison Yards Way, Madison, Wisconsin, unless otherwise noted. To confirm a meeting or to request a complete copy of the council's agenda, please call the listed contact person. The council may consider materials or items filed after the transmission of this notice. Interpreters for the hearing impaired provided upon request by contacting the Affirmative Action Officer, 608-266-2112

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

|  |  |   |  |
|--|--|---|--|
| <b>1) Name and Title of Person Submitting the Request:</b><br><br>Tom Ryan, Executive Director of the Medical Examining Board  |  | <b>2) Date When Request Submitted:</b><br><br>10/30/2018<br>Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul> |  |
| <b>3) Name of Board, Committee, Council, Sections:</b><br><br>Medical Examining Board Licensure Forms Committee  |  |   |  |
| <b>4) Meeting Date:</b><br><br>11/14/2018  | <b>5) Attachments:</b><br><input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | <b>6) How should the item be titled on the agenda page?</b><br><br>Review of Application and Renewal Forms  |  |
| <b>7) Place Item in:</b><br><input checked="" type="checkbox"/> Open Session<br><input type="checkbox"/> Closed Session<br><input type="checkbox"/> Both   |  | <b>8) Is an appearance before the Board being scheduled? If yes, who is appearing?</b><br><br>Yes. Zachary Hendrickson, Supervisor, Health Team, and Joe Nartowicz, Supervisor, Renewal Office, Division of Professional Credential Processing  | <b>9) Name of Case Advisor(s), if required:</b><br><br>N/A |
| <b>10) Describe the issue and action that should be addressed:</b><br><br>Zachary Hendrickson and Joe Nartowicz will appear before the Committee to present the physician application and renewal forms. |  |   |  |
| <b>11) Authorization</b>   |  |   |  |
| Signature of person making this request  |  | Date  |  |
| Supervisor (if required)   |  | Date  |  |
| Bureau Director signature (indicates approval to add post agenda deadline item to agenda)  |  | Date  |  |

# Wisconsin Department of Safety and Professional Services

**Mail To:** P.O. Box 8935  
Madison, WI 53708-8935  
**FAX #:** (608) 261-7083  
**Phone #:** (608) 266-2112

**Office Location:** 4822 Madison Yards Way  
Madison, WI 53705  
**E-Mail:** [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
**Website:** <http://dsps.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**), or ECFMG certificate. You may obtain this service online at [www.fsmb.org](http://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
- 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](http://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](http://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 the 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](mailto: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@wi.gov](mailto:DSPSCREDMEDBD@wi.gov) or faxed to (608) 261-7083. If you have further questions regarding this report, contact the NPDB helpline at 1-800-767-6732.

## **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.DOProfiles.org](http://www.DOProfiles.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 for 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  |

# Wisconsin Department of Safety and Professional Services

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 FAX #: (608) 261-7083  
 Phone #: (608) 266-2112

Office Location: 4822 Madison Yards Way  
 Madison, WI 53705  
 E-Mail: [dspd@wisconsin.gov](mailto:dspd@wisconsin.gov)  
 Website: <http://dspd.wi.gov>

## 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. Stats. § 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK  Your name, address, telephone and electronic 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 #  | 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:**  White, not of Hispanic origin  American Indian or Alaskan  Hispanic  
 Black, not of Hispanic origin  Asian or Pacific Islander  Other

**Sex:**  M  F

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

Email Address

|  |   |
|--|---|
| 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               | Date Degree Granted  |
| <input type="text"/> | <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.

Please check this box if you are applying for Administrative Physician Licensure

|  |   |
|--|---|
| <input type="checkbox"/> I am seeking a Veteran Fee Waiver<br>(for Initial Credential Fee only, see page 2 for further information)                        | <input type="checkbox"/> Endorsement of LMCC (taken after 1/1/78)<br>\$75.00 Initial Credential Fee<br><b>\$75.00 Total Fee Attached</b>                                |
| <input type="checkbox"/> Endorsement of Steps 1, 2 and 3 of USMLE<br>\$75.00 Initial Credential Fee<br><b>\$75.00 Total Fee Attached</b>                   | <input type="checkbox"/> Reciprocity of State Board Exam (Taken Prior to 1972)<br>\$141.00 Reciprocal Credential Fee<br><b>\$141.00 Total Fee Attached</b>              |
| <input type="checkbox"/> Endorsement of National Boards (MD or DO), (NBME or NBOME)<br>\$75.00 Initial Credential Fee<br><b>\$75.00 Total Fee Attached</b> | <input type="checkbox"/> Visiting Physician<br>\$141.00 Reciprocal Credential Fee<br><b>\$141.00 Total Fee Attached</b>   |
| <input type="checkbox"/> Endorsement of FLEX<br>\$75.00 Initial Credential Fee<br><b>\$75.00 Total Fee Attached</b>  | <input type="checkbox"/> Re-Registration (license expired more than 5 years)<br>\$141.00 Renewal Fee<br>\$ 25.00 Late Renewal Fee<br><b>\$166.00 Total Fee Attached</b> |

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:**

- Application (**Form #570**) and appropriate fee
- 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
- 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 <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.WISVETS.com](http://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 <http://dsps.wi.gov> and select the "Professional Credential Renewal Information."

**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.**)

| <u>DATES</u><br>(Month, Year)  | <u>TYPE</u>  | <u>NAME OF SCHOOL, HOSPITAL<br/>CLINIC OR OTHER</u> | <u>LOCATION</u><br>(City, State and Country)  |
|--|--|---|---|
| (From) <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/><br><br>(To) <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/> | <input type="checkbox"/> Post Grad<br><input type="checkbox"/> Intern<br><input type="checkbox"/> Resident<br><input type="checkbox"/> Fellow<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |   | (City) <input style="width: 100%; height: 20px;" type="text"/><br>(State) <input style="width: 60%; height: 20px;" type="text"/><br>(Country) <input style="width: 100%; height: 20px;" type="text"/> |
| (From) <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/><br><br>(To) <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/> | <input type="checkbox"/> Post Grad<br><input type="checkbox"/> Intern<br><input type="checkbox"/> Resident<br><input type="checkbox"/> Fellow<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |   | (City) <input style="width: 100%; height: 20px;" type="text"/><br>(State) <input style="width: 60%; height: 20px;" type="text"/><br>(Country) <input style="width: 100%; height: 20px;" type="text"/> |
| (From) <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/><br><br>(To) <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/> | <input type="checkbox"/> Post Grad<br><input type="checkbox"/> Intern<br><input type="checkbox"/> Resident<br><input type="checkbox"/> Fellow<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |   | (City) <input style="width: 100%; height: 20px;" type="text"/><br>(State) <input style="width: 60%; height: 20px;" type="text"/><br>(Country) <input style="width: 100%; height: 20px;" type="text"/> |
| (From) <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/><br><br>(To) <input style="width: 40px;" type="text"/> / <input style="width: 40px;" type="text"/> | <input type="checkbox"/> Post Grad<br><input type="checkbox"/> Intern<br><input type="checkbox"/> Resident<br><input type="checkbox"/> Fellow<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |   | (City) <input style="width: 100%; height: 20px;" type="text"/><br>(State) <input style="width: 60%; height: 20px;" type="text"/><br>(Country) <input style="width: 100%; height: 20px;" type="text"/> |

# Wisconsin Department of Safety and Professional Services

**LIST ALL HOSPITALS/FACILITIES/EMPLOYERS WHERE YOU PREVIOUSLY HAD OR HELD STAFF PRIVILEGES, EMPLOYMENT, OR APPOINTMENTS DURING THE LAST FIVE YEARS:**

List in chronological order all facilities where you have moonlighted. Do not list the facilities where you were strictly in a training capacity (i.e. resident, fellow, and intern)

**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><br>(Month, Year)  | <u>TYPE</u>  | <u>NAME OF HOSPITAL OR CLINIC</u> | <u>LOCATION</u><br>(City, State and Country)  |
|--|--|-----------------------------------|---|
| (From) <input type="text"/> / <input type="text"/><br>(To) <input type="text"/> / <input type="text"/> | <input type="checkbox"/> Privilege<br><input type="checkbox"/> Employment<br><input type="checkbox"/> Appointment<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |                                   | (City) <input type="text"/><br>(State) <input type="text"/><br>(Country) <input type="text"/> |
| (From) <input type="text"/> / <input type="text"/><br>(To) <input type="text"/> / <input type="text"/> | <input type="checkbox"/> Privilege<br><input type="checkbox"/> Employment<br><input type="checkbox"/> Appointment<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |                                   | (City) <input type="text"/><br>(State) <input type="text"/><br>(Country) <input type="text"/> |
| (From) <input type="text"/> / <input type="text"/><br>(To) <input type="text"/> / <input type="text"/> | <input type="checkbox"/> Privilege<br><input type="checkbox"/> Employment<br><input type="checkbox"/> Appointment<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |                                   | (City) <input type="text"/><br>(State) <input type="text"/><br>(Country) <input type="text"/> |
| (From) <input type="text"/> / <input type="text"/><br>(To) <input type="text"/> / <input type="text"/> | <input type="checkbox"/> Privilege<br><input type="checkbox"/> Employment<br><input type="checkbox"/> Appointment<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |                                   | (City) <input type="text"/><br>(State) <input type="text"/><br>(Country) <input type="text"/> |
| (From) <input type="text"/> / <input type="text"/><br>(To) <input type="text"/> / <input type="text"/> | <input type="checkbox"/> Privilege<br><input type="checkbox"/> Employment<br><input type="checkbox"/> Appointment<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |                                   | (City) <input type="text"/><br>(State) <input type="text"/><br>(Country) <input type="text"/> |
| (From) <input type="text"/> / <input type="text"/><br>(To) <input type="text"/> / <input type="text"/> | <input type="checkbox"/> Privilege<br><input type="checkbox"/> Employment<br><input type="checkbox"/> Appointment<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |                                   | (City) <input type="text"/><br>(State) <input type="text"/><br>(Country) <input type="text"/> |
| (From) <input type="text"/> / <input type="text"/><br>(To) <input type="text"/> / <input type="text"/> | <input type="checkbox"/> Privilege<br><input type="checkbox"/> Employment<br><input type="checkbox"/> Appointment<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |                                   | (City) <input type="text"/><br>(State) <input type="text"/><br>(Country) <input type="text"/> |
| (From) <input type="text"/> / <input type="text"/><br>(To) <input type="text"/> / <input type="text"/> | <input type="checkbox"/> Privilege<br><input type="checkbox"/> Employment<br><input type="checkbox"/> Appointment<br><input type="checkbox"/> Practice<br><input type="checkbox"/> Other |                                   | (City) <input type="text"/><br>(State) <input type="text"/><br>(Country) <input type="text"/> |

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

|                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |                      |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|

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 familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2.  | Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? <b>If yes, give details on an attached sheet, including the name of the profession and the agency.</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3.  | Have you ever failed to pass any state board examination, national board examination (NBME or NBOME), FLEX, or USMLE examination? <b>If yes, provide details below:</b><br><br><div style="border: 1px solid black; height: 20px; width: 100%;"></div>  | <input type="checkbox"/> Yes <input type="checkbox"/> 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? <b>If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5.  | Is disciplinary action pending against you in any jurisdiction? <b>If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 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. <b>If yes, submit Convictions and Pending Charges (Form #2252).</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7.  | Are you incarcerated, on probation, or on parole for any conviction? <b>If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.</b>  | <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? <b>If yes, Malpractice Suits or Claims (Form #2829).</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9.  | Have your hospital privileges ever been limited or removed? <b>If yes, give details on an attached sheet.</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. | Are you registered or licensed in any other profession(s)? <b>If yes, state what profession(s) and in what state(s):</b><br><br><div style="border: 1px solid black; height: 20px; width: 100%;"></div>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. | Have you ever been credentialed under any other name(s)? <b>If yes, state name(s) credentialed under:</b><br><br><div style="border: 1px solid black; height: 20px; width: 100%;"></div>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. | Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? <b>If yes, give details on an attached sheet.</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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 directions of a licensed health care practitioner.

# Wisconsin Department of Safety and Professional Services

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

|     |   |  |
|-----|---|--|
| 13. | Do you have a medical condition, which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If no, you may skip questions 14 and 15. <b>If yes, please explain.</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. | If yes to question 13, 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? <b>If yes, please explain.</b>                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. | If yes to question 13, 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? <b>If yes, please explain.</b>                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. | Does your use of chemical substance(s) in any way impair, or limit your ability to practice medicine with reasonable skill and safety? <b>If yes, please explain.</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. | Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? <b>If yes, please explain.</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. | Are you currently 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 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? <b>If yes, please explain.</b> | <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.

**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:  /  /

# Wisconsin Department of Safety and Professional Services

**Mail To:** P.O. Box 8935  
Madison, WI 53708-8935  
**FAX #:** (608) 261-7083  
**Phone #:** (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703  
E-Mail: [dsps@wisconsin.gov](mailto: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:  /  /

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  /  /

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Madison, WI 53703  
E-Mail: [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
Website: <http://dsps.wi.gov>

## MEDICAL EXAMINING BOARD

### PHYSICIAN DATA CENTER PRACTITIONER PROFILE REPORT (Not necessary if utilizing FCVS)

**APPLICANT:** Please complete this form and forward directly to the Federation of State Medical Boards.

Email: [Boardinquiry@fsmb.org](mailto:Boardinquiry@fsmb.org)

Fax: (817) 868-4099

Mail: Federation of State Medical Board, Inc. (FSMB)  
400 Fuller Wiser Rd Suite 300  
Eules, TX 76039-3855

---

The State of Wisconsin requests a Physician Data Center Profile concerning the following individual:

Physician's Name

 /  / 

Date of Birth

Medical School

ECFMG Number

---

Physician's Signature

Degree

 -  - 

Social Security Number

 /  / 

Year of Graduation

 /  / 

Date

---

**FEDERATION OF STATE MEDICAL BOARDS:** Please respond directly to the Medical Examining Board.

Email: [DspsCredMedBD@wisconsin.gov](mailto:DspsCredMedBD@wisconsin.gov)

Mail: DSPS

Attn: Medical Examining Board  
1400 East Washington Avenue  
P.O. Box 8935  
Madison, WI 53708-8935

# Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935  
Madison, WI 53708-8935

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1400 E. Washington Avenue  
Madison, WI 53703

E-Mail: [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
Website: <http://dsps.wi.gov>

## MEDICAL EXAMINING BOARD

### MEDICAL EDUCATION VERIFICATION FORM

(Not necessary if utilizing FCVS)

**APPLICANT:** Please forward this form to your medical school.

**MEDICAL SCHOOL:** The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant's Name:

Social Security #: (for school use to locate your records)    -   -

Medical School:

Medical School Address:

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 1. Did this Physician attend the medical school noted above?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. What were the applicant's dates of enrollment in this medical school?   |                          |                          |
| Start Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>  |                          |                          |
| End Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>  |                          |                          |
| 3. Did this Physician graduate from this medical school?<br><b>If no, please attach explanation on a separate sheet.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Degree Granted: <input type="text"/>   |                          |                          |
| Date Degree Granted: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>   |                          |                          |
| 4. Did this Physician take a leave of absence during his/her attendance at this medical school?<br><b>If yes, please attach explanation on a separate sheet.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did this Physician have a record of unexcused absences during his/her attendance at this medical school?<br><b>If yes, please attach explanation on a separate sheet.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Was this Physician ever disciplined or under investigation during his/her attendance at this medical school? <b>If yes, please attach explanation on a separate sheet and indicate if this constitutes adverse formal action.</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Were any special requirements imposed on this Physician that were not required of all other students at his/her level of education? <b>If yes, please attach explanation on a separate sheet.</b>                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Was this Physician recommended for post-graduate training?  | <input type="checkbox"/> | <input type="checkbox"/> |

Printed Name of Dean:

Signature: \_\_\_\_\_ Date   /   /

**Medical School, please return directly to:**

#### DSPS

Attn: Medical Examining Board  
P.O. Box 8935  
Madison, WI 53708-8935

**Or you may fax/email with facility cover sheet/letter to:** (608) 261-7083 or [DSpscCredMedBD@wisconsin.gov](mailto:DSpscCredMedBD@wisconsin.gov).

# Wisconsin Department of Safety and Professional Services

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 Website: <http://dsps.wi.gov>

## MEDICAL EXAMINING BOARD

### CERTIFICATE OF POST-GRADUATE TRAINING

(Not necessary if utilizing FCVS)

**APPLICANT:** Please forward this form to your post-graduate training program(s) for completion.

**TRAINING PROGRAM:** The Medical Examining Board requests that you complete this form concerning the following individual:

|  |  |
|--|--|
| <b>Applicant/Physician's Name:</b>       | <input style="width: 95%;" type="text"/>   |
| <b>Hospital/Program Name:</b>            | <input style="width: 95%;" type="text"/>   |
| <b>Hospital/Program Address:</b>         | <input style="width: 95%;" type="text"/>   |
| <b>Hospital/Program's Daytime Phone:</b> | <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> |

1. In what type and level(s) of training did this Physician participate at your facility? Indicate below each level of training in which the above named Physician participated in your program. Provide start/end dates, type of training, and whether credit was given for the training.

| DATES OF TRAINING(month/day/year)   | TYPE OF SPECIALTY TRAINING               | FULL CREDIT   | PARTIAL CREDIT  |
|---|--|---|---|
| PGY 1:<br><input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> to <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/>                | <input style="width: 95%;" type="text"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| PGY 2:<br><input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> to <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/>                | <input style="width: 95%;" type="text"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| PGY 3:<br><input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> to <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/>                | <input style="width: 95%;" type="text"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| PGY 4:<br><input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> to <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/>                | <input style="width: 95%;" type="text"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| Fellowship:<br><input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> to <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/>           | <input style="width: 95%;" type="text"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| Transitional (Other):<br><input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> to <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> | <input style="width: 95%;" type="text"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |

# Wisconsin Department of Safety and Professional Services

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 2. Was the internship/residency/fellowship in the United States or Canada accredited by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada (RCPC), or the College of Family Physicians of Canada (CFPC)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Did the Physician either complete the training program in good standing, or is the Physician currently in the training program and in good standing? <b>If no, please attach explanation on a separate sheet.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Was this Physician recommended for the Board Certification Examination in this specialty?   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b><u>If you answer Yes to questions 5-14, attach an explanation on a separate sheet.</u></b>  |                          |                          |
| 5. Was the Physician asked, or required, to repeat any portion of the training program?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while in the program? <b>If yes, please indicate if this constitutes an adverse formal action.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Was this Physician granted a leave of absence while in the training program?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Did this individual have a record of unexcused absences during his/her attendance in this training program?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Were any restrictions and/or special requirements placed on this Physician's activities that were not placed on all other residents/fellows at his/her level of training?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Were any formal patient or staff complaints filed against this Physician?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Were any incident reports filed involving the professional behavior or conduct of this Physician?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Was this Physician ever subject to non-routine monitoring while in the training program?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Were any malpractice actions filed naming this Physician as a defendant that involved his/her period of training in the program?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is there any additional information in this Physician's file that would assist the Board in determining this applicant's eligibility for licensure?  | <input type="checkbox"/> | <input type="checkbox"/> |

**FOR PHYSICIANS CURRENTLY COMPLETING PGY 2 YEAR:**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 15. Has the Physician completed and received credit for 12 consecutive months of training program and is expected to continue in the program and complete at least 24 months of post-graduate training? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

**If yes,** please indicate the expected completion date of the 24 months of training:  /  /

Printed Name of Program Director:

Signature of Program Director:  Date  /  /

**Post-graduate Training Program, please return directly to:**

DSPS  
 Attn: Medical Examining Board  
 P.O. Box 8935  
 Madison, WI 53708-8935

**Alternatively, you may fax/email with facility cover sheet/letter to:** (608) 261-7083 or [DSPSCredMedBD@wisconsin.gov](mailto:DSPSCredMedBD@wisconsin.gov).

# Wisconsin Department of Safety and Professional Services

**Mail To:** P.O. Box 8935  
Madison, WI 53708-8935  
**FAX #:** (608) 261-7083  
**Phone #:** (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703  
E-Mail: [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
Website: <http://dsps.wi.gov>

## MEDICAL EXAMINING BOARD

### HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

**APPLICANT:** Please forward this form to all hospitals, facilities, and employers where you have had staff privileges, employment, or appointment during the last five (5) years.

**Hospital/Facility/Employer:** The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name:

Name of Hospital/Facility/Employer:

Hospital/Facility/Employer's Address:

Hospital/Facility/Employer's Daytime Phone:    -    -

**Hospital/Facility/Employer, you must answer all of the following questions and provide any additional information in order for this form to be considered complete.**

1. What position did this Physician hold at your facility or under your employment?

2. What were this Physician's dates of employment or staff privileges at your facility?

  /   /   to   /   /  

NOTE: If Physician is still employed/privileged, end date should indicate "to present" or "to current."

|  | <b>YES</b>               | <b>NO</b>                |
|--|--------------------------|--------------------------|
| 3. Did this Physician either leave your employment in good standing, or is currently employed and in good standing? <b>If no, please attach explanation on a separate sheet.</b> | <input type="checkbox"/> | <input type="checkbox"/> |

**If you answer Yes to questions 4-9, attach an explanation on a separate sheet.**

|   |                          |                          |
|---|--------------------------|--------------------------|
| 4. Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

|   |                          |                          |
|---|--------------------------|--------------------------|
| 5. Was this Physician granted a leave of absence while employed by you or at your facility? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

|  |                          |                          |
|--|--------------------------|--------------------------|
| 6. Did this Physician have a record of unexcused absences during his/her attendance at this facility or under your employment? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

|   |                          |                          |
|---|--------------------------|--------------------------|
| 7. Were any restrictions or special requirements placed on this Physician's activities that were not placed on all other employees/staff holding similar positions? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

|   |                          |                          |
|---|--------------------------|--------------------------|
| 8. Were any restrictions placed on this Physician's privileges? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

|  |                          |                          |
|--|--------------------------|--------------------------|
| 9. Were any formal patient or staff complaints filed against this Physician? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

# Wisconsin Department of Safety and Professional Services

If you answer Yes to questions 10-15, attach an explanation on a separate sheet.

- |   | <u>YES</u>               | <u>NO</u>                |
|---|--------------------------|--------------------------|
| 10. Was this Physician denied hospital privileges while employed by you?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Were any incident reports filed involving the professional conduct or behavior of this Physician?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Was this Physician ever subject to non-routine monitoring while at your facility?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Was this Physician involuntarily removed from a call schedule for cause?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Was this Physician subject to non-routine quality assessment review?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Was this Physician the subject of a negative review by a quality assurance or departmental committee? | <input type="checkbox"/> | <input type="checkbox"/> |

Name/title of Individual Supplying Information:

Signature: \_\_\_\_\_

Date  /  /

**Hospital/Facility/Employer, please return directly to:**

DSPS  
Attn: Medical Examining Board  
P.O. Box 8935  
Madison, WI 53708-8935

**Or you may fax/email with facility cover sheet/letter to:** (608) 261-7083 or [DSPSCredMedBD@wisconsin.gov](mailto:DSPSCredMedBD@wisconsin.gov).



# Wisconsin Department of Safety and Professional Services

|  |  |  |
|--|--|--|
| <b>Parties:</b>                              | <input type="text"/>   |  |
| <b>Date Filed:</b>                           | <input type="text"/> / <input type="text"/> / <input type="text"/> | <b>Date Resolved:</b> <input type="text"/> / <input type="text"/> / <input type="text"/> |
| <b>Court and Case No.</b>                    | <input type="text"/>   | <b>Disposition:</b> <input type="text"/>   |
| <b>Description of Legal Action or Claim:</b> |  |  |

|  |  |  |
|--|--|--|
| <b>Parties:</b>                              | <input type="text"/>   |  |
| <b>Date Filed:</b>                           | <input type="text"/> / <input type="text"/> / <input type="text"/> | <b>Date Resolved:</b> <input type="text"/> / <input type="text"/> / <input type="text"/> |
| <b>Court and Case No.</b>                    | <input type="text"/>   | <b>Disposition:</b> <input type="text"/>   |
| <b>Description of Legal Action or Claim:</b> |  |  |

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Madison, WI 53703  
**E-Mail:** [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
**Website:** <http://dsps.wi.gov>

## MEDICAL EXAMINING BOARD

### INFORMATION FOR COMPLETING APPLICATION FOR MEDICINE AND SURGERY FOR INDIVIDUALS WITH A CURRENT UNRESTRICTED MINNESOTA LICENSE

**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.

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 nor waive supporting documents even in emergency situations.

**PLEASE READ BEFORE COMPLETING YOUR APPLICATION:** This application **does not** apply to individuals who hold a MN Telemedicine license. To qualify for this license you must currently hold an unrestricted State of Minnesota license.

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

- Application (**Form #2862**) and fees
- National Practitioner Data Bank Report
- Certification of Post Graduate Training (**Form #2165**)
- Copies of malpractice suit and court documents with allegations and settlement if applicable, complete Malpractice Suits or Claims (**Form #2829**)
- Authorization and Waiver (**Form #571**)
- Provide a current copy of your unrestricted Minnesota license
- Physician Profile Data Report from the American Medical Association or American Osteopathic Association
- Physician Data Center Practitioner Profile from the Federation of State Medical Boards (**Form #1445**)
- Convictions and Pending Charges (**Form #2252**) if applicable

**VERIFICATION OF MEDICAL LICENSES IS REQUIRED:** You are required to submit a current copy of your unrestricted Minnesota license to the Wisconsin Medical Examining Board.

**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/pract/selfQueryBasics.jsp>. Select the option that reads, "Start a Self-Query for an Individual." 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@wi.gov](mailto:DSPSCREDMEDBD@wi.gov), or faxed to (608) 261-7083. If you have further questions regarding this report, contact the NPDB helpline at 1-800-767-6732.

# Wisconsin Department of Safety and Professional Services

**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: American Medical Association Physician Profile Data at: <https://profiles.ama-assn.org/amaprofiles/>. Please select the option for "Physicians Only Requests for Profiles to be sent to Licensing Boards" and follow the steps given on the AMA website.

All DO's applying for licensure must use the AOA website at [www.DOPprofiles.org](http://www.DOPprofiles.org).

**PHYSICIAN DATA CENTER PRACTITIONER PROFILE REPORT:** Request Report from the Federation of State Medical Boards (**Form #1445**).

## **ORAL INTERVIEWS:**

The Oral Interview process in the State of Wisconsin was created under Wis. Admin. Code § MED 1.06. **If you are selected to appear for an Oral Interview**, you will be scheduled to appear before the Review Panel at one of the regularly scheduled Board meetings.

### **Panel Review: Oral Interviews:**

- a) In addition to the National exam, an applicant **may** be required to complete an Oral Interview if the applicant:
1. Has a medical condition, which in any way impairs or limits the applicant's ability to practice medicine and surgery with reasonable skill and safety.
  2. Uses chemical substances to impair in any way the applicant's ability to practice medicine and surgery with reasonable skill and safety.
  3. Has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction.
  4. Has been found to be negligent in the practice of medicine or has been a party in a lawsuit in which it was alleged that the applicant had been negligent in the practice of medicine.
  5. Has been convicted of a crime the circumstances of which substantially relate to the practice of medicine.
  6. Has lost, had reduced, or had suspended his or her hospital staff privileges, or has failed to continuously maintain hospital privileges during the applicant's period of licensure following post-graduate training.
  7. Has graduated from a medical school not approved by the Board.
  8. Has been diagnosed as suffering from Pedophilia, Exhibitionism, or Voyeurism.
  9. Has within the past two (2) years engaged in the illegal use of controlled substances.
  10. Has been subject to adverse formal action during the course of medical education, postgraduate training, hospital practice, or other medical employment.
  11. Has not practiced medicine and surgery for a period of three (3) years prior to application, unless the applicant has been graduated from a school of medicine within that period.
- b) An application filed under Wis. Admin. Code § Med 1.02 shall be reviewed by an Application Review Panel of at least two (2) Board members designated by the Chairperson of the Board. The Panel shall determine whether the applicant is eligible for a regular license without completing an Oral Interview. An applicant can also be required to take an Oral Interview under Wis. Admin. Code Med § 1.08(2), if the applicant has been examined four (4) or more times before achieving a passing grade.

## **MAILING INSTRUCTIONS:**

Mail the Application (**Form #2862**), 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  
1400 E WASHINGTON AVE  
MADISON WI 53703**

# 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 Practice                        | 41 | 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 | Research                             | 34 |
| Internal Medicine - Cardiology         | 05 | Retired                              | 24 |
| Internal Medicine - Pulmonary Medicine | 45 | Rheumatology                         | 57 |
| Neonatology                            | 63 | School Physician                     | 52 |
| Nephrology                             | 40 | Surgery - Cardiovascular             | 44 |
| Neurology                              | 10 | 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 |

# Wisconsin Department of Safety and Professional Services

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**Website:** <http://dsps.wi.gov>

## MEDICAL EXAMINING BOARD

### APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY FOR INDIVIDUALS WITH A CURRENT UNRESTRICTED MINNESOTA LICENSE

(This application does not apply for individuals who hold a Minnesota Telemedicine license.)

**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).

|  |   |                                   |  |
|--|---|-----------------------------------|--|
| <b>Last Name</b><br><input type="text"/> | <b>First Name</b><br><input type="text"/> | <b>MI</b><br><input type="text"/> | <b>Former / Maiden Name(s)</b><br><input type="text"/> |
|--|---|-----------------------------------|--|

|   |   |
|---|---|
| <b>Address</b> (street, city, state, zip)<br><input type="text"/> | <b>Daytime Telephone Number</b><br><input type="text"/> |
|---|---|

|   |  |
|---|--|
| <b>Mailing Address</b> (if different)<br><input type="text"/> | <b>Date of Birth</b><br><input type="text"/> |
|---|--|

|  |  |
|--|--|
| <b>Social Security #</b><br><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. |
|--|--|

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

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

**Email Address**

|  |   |
|--|---|
| <b>Medical School Name</b><br><input type="text"/>                             | <b>Medical School Address</b> (street, city, state)<br><input type="text"/> |
| <b>Date Degree Granted</b><br><input type="text"/>                             | <b>Degree</b><br><input type="text"/>                                       |
| <b>Specialty</b> (see page iii for a listing of codes)<br><input type="text"/> | <b>Specialty Code</b><br><input type="text"/>                               |

**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)
- Reciprocity of MN State Board**  
 \$ 141.00 Reciprocal Initial Credential Fee  
 \$ 141.00 Total Fee Attached

**For Receiving Use Only (20/21)**

# Wisconsin Department of Safety and Professional Services

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

- Application (**Form #2862**) and appropriate fee
- National Practitioner Data Bank Report
- Certification of Post-graduate training (**Form #2165**)
- Provide a current copy of your unrestricted Minnesota license
- Physician Profile Data Report from the American Medical Association or American Osteopathic Association
- Physician Data Center Practitioner Profile from the Federation of State Medical Boards (**Form #1445**)
- Authorization and Waiver (**Form#571**)
- 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.

**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](http://www.WISVET.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 <http://dsps.wi.gov> and select the “Professional Credential Renewal Information.”

**POST-GRADUATE TRAINING:** Account for all post-graduate training activities. All facilities listed below must complete (**Form #2165**) and return directly to the Department to certify your completion of training. (Attach additional sheets, if necessary.)

| Dates<br>(Month/Year)  | Type  | Name of School, Hospital Clinic, or Other | Location<br>(City, State and Country)   |
|--|---|---|---|
| (From)<br><input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/><br><br>(To)<br><input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/> | <input type="checkbox"/> Post-Grad<br><input type="checkbox"/> Intern<br><input type="checkbox"/> Resident<br><input type="checkbox"/> Fellow |   | (City)<br><input style="width: 100%; height: 20px;" type="text"/><br><br>(State)<br><input style="width: 30px; height: 20px;" type="text"/><br><br>(Country)<br><input style="width: 100%; height: 20px;" type="text"/> |
| (From)<br><input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/><br><br>(To)<br><input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/> | <input type="checkbox"/> Post-Grad<br><input type="checkbox"/> Intern<br><input type="checkbox"/> Resident<br><input type="checkbox"/> Fellow |   | (City)<br><input style="width: 100%; height: 20px;" type="text"/><br><br>(State)<br><input style="width: 30px; height: 20px;" type="text"/><br><br>(Country)<br><input style="width: 100%; height: 20px;" type="text"/> |
| (From)<br><input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/><br><br>(To)<br><input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/> | <input type="checkbox"/> Post-Grad<br><input type="checkbox"/> Intern<br><input type="checkbox"/> Resident<br><input type="checkbox"/> Fellow |   | (City)<br><input style="width: 100%; height: 20px;" type="text"/><br><br>(State)<br><input style="width: 30px; height: 20px;" type="text"/><br><br>(Country)<br><input style="width: 100%; height: 20px;" type="text"/> |

# Wisconsin Department of Safety and Professional Services

**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?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2.  | Have you ever surrendered, resigned, canceled, or been denied a professional license, or other credential in Wisconsin, or any other jurisdiction? <b>If yes, give details on an attached sheet, including the name of the profession and the agency.</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3.  | Have you ever failed to pass any state board examination, national board (NBME or NBOME), FLEX, or, USMLE examination? <b>If yes, provide details below:</b><br><br><div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>  | <input type="checkbox"/> Yes <input type="checkbox"/> 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? <b>If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5.  | Is disciplinary action pending against you in any jurisdiction? <b>If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> 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? <b>If yes, submit Convictions and Pending Charges (Form #2252).</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7.  | Are you incarcerated, on probation, or on parole for any conviction? <b>If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.</b>  | <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? <b>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).</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9.  | Have your hospital privileges ever been limited or removed? <b>If yes, please explain.</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. | Are you registered or licensed in any other profession(s)? <b>If yes, state what profession(s) and in what state(s):</b><br><br><div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. | Have you ever been credentialed under any other name(s)? <b>If yes, state name(s) credentialed under:</b><br><br><div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. | Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? <b>If yes, give details on an attached sheet.</b>   | <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 directions of a licensed health care practitioner.

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

|     |  |  |
|-----|--|--|
| 11. | Do you have a medical condition, which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? <b>If yes, please explain.</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. | Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? <b>If yes, please explain.</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. | 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? <b>If yes, please explain.</b>                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. | 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? <b>If yes, please explain.</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. | Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? <b>If yes, please explain.</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. | Are you currently engaged in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. | 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? <b>If yes, please explain.</b> | <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.

# Wisconsin Department of Safety and Professional Services

## 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:  /  /

# Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935  
Madison, WI 53708-8935  
FAX #: (608) 261-7083  
Phone #: (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703  
E-Mail: [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
Website: <http://dsps.wi.gov>

## MEDICAL EXAMINING BOARD

### JOINT COMMISSION CERTIFIED HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

The State of Wisconsin requests Joint Commission Certified employers to complete this form for all hospitals, facilities, and where the below physician currently has or previously held staff privileges, or employment during the last five (5) years. **You must answer all of the following questions and provide any additional information in order for this form to be considered complete.**

PHYSICIAN'S NAME:

NAME/LOCATION OF FACILITIES: Please attach a complete list of all facilities where the above physician has had employment or staff privileges under your employment. List should include the name of the facility, location (city/state), and dates employed (mo/yr-start/end). The list should be given in alphabetical order.

JOINT COMMISSION CERTIFIED EMPLOYER NAME:

JOINT COMMISSION CERTIFIED EMPLOYER ADDRESS:

JOINT COMMISSION CERTIFIED EMPLOYER TELEPHONE #: --

JOINT COMMISSION CERTIFIED EMPLOYER ORGANIZATION NUMBER: Submit your number in the spaces below.

JOINT COMMISSION CERTIFIED EMPLOYER EMAIL ADDRESS: Submit your email address in the spaces below.

- |  | <u>YES</u>   | <u>NO</u>                |
|--|--|--------------------------|
| 1. Has your entity received Joint Commission Certified certification?  | <input type="checkbox"/>   | <input type="checkbox"/> |
| 2. What position does the physician hold under your employment?  | <input type="text"/>   |                          |
| 3. List the physician's dates of employment or staff privileges under your employment:   |  |                          |
|  | <input type="text"/> / <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> / <input type="text"/> |                          |
| 4. Did the physician either leave your employment in good standing or is currently employed and in good standing? <b>If no, please provide explanation on a separate sheet and attach to this form.</b>                              | <input type="checkbox"/>   | <input type="checkbox"/> |
| 5. Was the physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b> | <input type="checkbox"/>   | <input type="checkbox"/> |
| 6. Was the physician granted a leave of absence while employed at any of your facilities or under your employment? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b>                            | <input type="checkbox"/>   | <input type="checkbox"/> |

# Wisconsin Department of Safety and Professional Services

- |   | <u>YES</u>               | <u>NO</u>                |
|---|--------------------------|--------------------------|
| 7. Did this individual have a record of unexcused absences during his/her attendance at any of your facilities or under your employment? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b>                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees or staff holding similar positions? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Were any restrictions placed on this physician's privileges? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Were any formal patient or staff complaints filed against this physician? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Was the physician denied hospital privileges while employed by you? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Were any incident reports filed involving the professional conduct or behavior of the physician? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Was the physician ever subject to non-routine monitoring while at your facility? <b>If yes, please attach explanation on a separate sheet and attach to this form.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Was the physician involuntarily removed from a call schedule for cause? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Was the physician subject to non-routine quality assessment review? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Was the physician the subject of a negative review by a quality assurance or departmental committee? <b>If yes, please provide explanation on a separate sheet and attach to this form.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |

PRINT NAME AND TITLE OF JOINT COMMISSION CERTIFIED EMPLOYER/OFFICIAL SUPPLYING INFORMATION:

SIGNATURE OF JOINT COMMISSION CERTIFIED EMPLOYER/OFFICIAL SUPPLYING INFORMATION:

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DATE FORM WAS COMPLETED:  /  /

**JOINT COMMISSION CERTIFIED EMPLOYER, RETURN THIS FORM DIRECTLY TO:**

DSPS  
 ATTN: Medical Examining Board  
 P.O. Box 8935  
 Madison, WI 53708-8935

Or you may also fax /email with facility cover sheet /letter to: (608) 261-7083 or [DSPSCredMedBD@wisconsin.gov](mailto:DSPSCredMedBD@wisconsin.gov).

# Wisconsin Department of Safety and Professional Services

**Mail To:** P.O. Box 8935  
 Madison, WI 53708-8935  
**FAX #:** (608) 261-7083  
**Phone #:** (608) 266-2112

**Ship To:** 1400 E. Washington Avenue  
 Madison, WI 53703  
**E-Mail:** [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
**Website:** <http://dsps.wi.gov>

## DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES LICENSE TRANSITION ADDENDUM

Complete the appropriate section (A or B) below and return this Form (#3047) directly to DSPS. You may fax/email to: (608) 261-7083 or [DSpscREDMEDBD@wisconsin.gov](mailto:DSpscREDMEDBD@wisconsin.gov). Please allow 10-15 business days for this request to be reviewed and processed.

|   |  |  |  |
|---|--|--|--|
| <b>PLEASE TYPE OR PRINT INK</b>   |  |  |  |
| <input type="checkbox"/> 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)  |  |  |  |
| <b>License Holder Last Name</b>   | <b>First Name</b>                        | <b>MI</b>                                | <b>Former / Maiden Name(s)</b>           |
| <input style="width: 95%;" type="text"/>  | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> | <input style="width: 95%;" type="text"/> |
| <b>Wisconsin License #:</b> <input style="width: 20px; height: 20px;" type="text"/>   |  |  |  |
| <b>Type of License:</b> (check one): <input type="checkbox"/> MD <input type="checkbox"/> DO  |  |  |  |
| <p><b>Section A:</b> This section applies to individuals who currently hold a <u>Physician credential</u>, and are requesting the credential transition to an Administrative Physician credential.</p> <p><b>Please read carefully and sign/date below.</b></p> <p><input type="checkbox"/> I understand that per Wis. Admin. Code Med 23.04, I may no longer examine, care for, or treat patients. I no longer have the authority to prescribe drugs or controlled substances, delegate medical acts, issue opinions regarding medical necessity or conduct clinical trials on humans.</p> <p><input type="checkbox"/> I understand that my current license will expire and I will be issued a new license upon completion of my license transition.</p> <p><input type="checkbox"/> I understand that the grant date of the Administrative Physician license will be the same as the grant date of my original Physician license.</p> <p><input type="checkbox"/> I understand that I am subject to all Wisconsin laws and rules regarding Administrative Physicians.</p> <p><b>Signature:</b> <input style="width: 300px; height: 20px;" type="text"/>                      <b>Date:</b> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p>   |  |  |  |
| <p><b>Section B:</b> This section applies to individuals who currently hold an Administrative Physician credential and are requesting the credential transition to a Physician credential.</p> <p><b>Please read carefully and sign/date below.</b></p> <p><input type="checkbox"/> I understand that the Medical Examining Board will review my petition to return to active practice and may request additional information or an appearance before the Board to determine eligibility.</p> <p><input type="checkbox"/> I understand that the current license will expire and I will be issued a new license upon completion of my license transition.</p> <p><input type="checkbox"/> I understand that the grant date of the Physician license will be the same as the grant date of my Administrative Physician license.</p> <p><input type="checkbox"/> I understand that the restrictions per Wis. Admin. Code Med 23.04 remains in effect until the time that my license has transitioned.</p> <p><input type="checkbox"/> I understand that I am subject to all Wisconsin laws and rules regarding Physicians.</p> <p><input type="checkbox"/> My last date of active practice was <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p><b>Signature:</b> <input style="width: 300px; height: 20px;" type="text"/>                      <b>Date:</b> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> |  |  |  |

**State of Wisconsin  
Department of Safety and Professional Services  
MEDICINE AND SURGERY RENEWAL**

**Credential Renewal Fee Schedule:**

*due before 11/1/2017*

**Total Owed: \$166.00  
Total Paid: \$0.00  
Balance Owed: \$166.00**

It is time to renew your license/credential from the Department of Safety and Professional Services.

- Processing time varies and can be approximately 10-15 working days. If you would like your license/credential fully renewed, please have all paperwork to the department 10-15 days
- A late fee will be assessed if postmarked date is after the expiration date.
- **Please SEE REVERSE SIDE for additional information and requirements for renewal.**

Internet renewal is available at <http://dsps.wi.gov> under "Online Services."

- Avoid delays in your renewal due to incomplete or missing information. Renewing online is fast, easy and secure.
- You will need your license/credential number and PIN that appear on the coupon **below** to access online renewal.
- The DSPS no longer sends a hard copy of a new or renewed license/credential. Please see the "Important Information" section on the back of this notice.

For paper renewal, please follow the instructions below.

- Name and address information provided to the Department is available for public inspection under Wisconsin law.
- You may substitute a business address as your address of record on file with the Department.
- You may also check the box on the form below to declare that your street address and/or PO Box # not be disclosed on any list of ten or more individuals that the department furnishes to another person per Wis. Stat. § 440.14.
- Fill in the gray boxes on the form below to show the **amount paid**.
- Please pay by credit card, check or money order **made payable to DSPS (Department of Safety and Professional Services)**.

Please Note: For all credit and debit card transactions, a 2% convenience fee will be assessed and will appear as a separate charge on your statement. This fee is non-refundable.

COMPLETE ADDITIONAL INFORMATION ON REVERSE SIDE

020R1/16CH.440

Detach and return coupon with payment

**STATE OF WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES**

**Medicine and Surgery**

CREDENTIAL NO: STATUS: TOTAL DUE: DUE DATE: PIN:  
ACTIVE \$166.00 10/31/2017 KBHKK3

AMT PD. \$



VISA  MASTERCARD  AMEX  DISCOVER

CARD # : \_\_\_\_\_

EXP. DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

PLEASE PRINT NAME/ADDRESS  
CHANGES IN THE SPACE BELOW

Do not disclose my street address/PO Box # on lists

STATE OF WISCONSIN  
DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES  
PO BOX 2974  
MILWAUKEE WI 53201-2974

DO NOT WRITE BELOW THIS POINT - CONTINUED ON BACK

02000701500001410000166008

Additional Requirements for Renewal:

1. Review Legal Status Statement below.
2. Check, sign, date, and return the Certification of Continuing Education below.
3. Complete the Conviction Statement below.

**IMPORTANT INFORMATION:**

- If you do not renew your license/credential before 11/1/2017, you may not practice.
- By completing and returning my renewal paperwork to the DSPS, I understand that if information previously provided to the DSPS becomes invalid, incorrect or outdated, since the last renewal or issuance of my license/credential, I understand that I am obliged to provide this updated information to ensure the information on file for my license/credential remains current, valid, and truthful. I also understand that this includes and is not limited to license/credential holders of any of the credentials/licenses set forth in Wis. Stat. s. 440.03(13)(b) who is convicted of a felony or misdemeanor, since the issuance of the license/credential or since the last renewal, in the state or elsewhere shall notify the DSPS in writing of the date, place and nature of the conviction or finding within 48 hours after the entry of the judgment of conviction.
- The DSPS no longer sends a physical copy of a new or renewed license/credential. You should receive an email or a letter from the DSPS telling you to go online to print the license/credential off of our website. There is also an option for you to order a printed wall certificate or a Governor signed wall certificate from the DSPS for an additional \$10. (Note: The DSPS prints the same document as is available to print at home.)
- If you fail to renew within five years after license/credential expiration, you may be required to complete additional requirements to restore your license/credential.
- Making a false statement in connection with any application for license/credential is grounds for revocation or denial.
- Full payment must be received by the DSPS before your license/credential will be issued. If you do not apply for renewal by the renewal deadline, your license/credential will expire and you may no longer practice.

COMPLETE ADDITIONAL INFORMATION BELOW.

020R1/16CH.440

**Legal Status Statement:**

If you do not have a Social Security Number on file with us or are exempt from having a Social Security Number, and/or your legal status as a qualified alien or nonimmigrant lawfully present in the United States has changed since your last renewal (or the issuance of your license if you have not renewed before), please contact the Wisconsin Department of Safety and Professional Services at 608-266-2112 or [dspd@wisconsin.gov](mailto:dspd@wisconsin.gov). I have read and acknowledge this information.

**Certification of Continuing Education: (check, sign and date below)**

I have completed 30 hours\* of AMA or AOA Category I Continuing Education, including two (2) hours of a Board-approved course related to the Board's Opioid Prescribing Guidelines, pursuant to Wis. Admin. Code ch. Med 13\*\*. I will furnish evidence of completion to the Medical Examining Board upon request.

\*Three (3) months of approved post-graduate training is equivalent to 30 hours of Category I credits. Wis. Admin. Code ch. Med 13.04.

\*\*Pursuant to Wis. Admin. Code ch. Med 13.02(1g)(b), physicians that do NOT hold a U.S. Drug Enforcement Administration number to prescribe controlled substances are NOT required to complete two (2) hours of a Board-approved course relating to the Board's Opioid Prescribing Guidelines.

**Conviction Statement: (check one)**

Since your initial licensure or last renewal, do you have any pending charges and/or have you been convicted of any crimes (does not include minor traffic violations that do not involve alcohol or drugs, such as speeding, running stoplights, and seat belt violations).

YES  NO

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# 2017 Medicine & Surgery Renewal Instructions

## Step 1

- Log in using your license number and pin number. If you don't know your PIN, you can [click here](#) to use our PIN look-up tool located on our website.

### Wisconsin Department of Safety and Professional Services Web Applications

---

#### [Login](#)

[Application Status](#)  
[DSPS Home Page](#)  
[License Look-up](#)  
[Main Menu](#)  
[PIN Look-up](#)



#### User Login

Credential/License Number:

PIN:

[Forgot Your PIN?](#)

Building/Construction professionals should contact us directly at [DSPSSBCredentialing@wi.gov](mailto:DSPSSBCredentialing@wi.gov) (608) 266-2112 for address updates and questions about obtaining a copy of their credential.

New applicants or pending applicants are unable to change their name and address online. Please email the department at [dps@wisconsin.gov](mailto:dps@wisconsin.gov) and provide your application ID number, profession applied for and the changes.

## Step 2

- Once you have logged into the portal, select Renew License from the Main Menu.

### Main Menu

#### [Update Profile](#)

Update your name, mailing address, phone number and email address

#### [Renew License](#)

Complete all steps necessary to renew your license

#### [Payment Inquiry](#)

Check on the status of your payment after renewing.

#### [Print Wall Certificate](#)

Print your Wall Certificate.

#### [Download Wall Certificate](#)

Download your Wall Certificate.

#### [Print Wallet Card](#)

Print your Wallet Card.

#### [Download Wallet Card](#)

Download your Wallet Card.

#### [Print Governor-signed Wall Certificate](#)

Print your Governor-signed Wall Certificate.

#### [Download Governor-signed Wall Certificate](#)

Download your Governor-Signed Wall Certificate.

Wall Certificates and Governor Certificates can also be purchased for \$10. Complete and return this [order form](#).

#### [Logout](#)

Logout

### Step 3

- Carefully read through Step 3 then click continue.

#### Professional Credential Renewal

**Credential Number:** [REDACTED] **Profession:** Medicine and Surgery  
**Renew By:** 10/31/2017 **Renewal Fee:** \$141.00 **Late Fee:**

Welcome, let's begin your renewal.

**Please Note:** The online renewal process takes **2 full business days** to process fully in our system and payment will not post to your license until the following business day.

The Department of Safety and Professional Service (DPS) no longer sends a physical copy of a new or renewed license. You should receive an email or a letter from the DPS telling you to go online to print the license off of our website. There is also an option for you to order a printed wall certificate or a Governor signed wall certificate from DPS for an additional \$10. (Note: DPS prints the same document as is available to print at home.) Here is the link to the form: [Duplicate License/Governor Wall Cert Order Form](#).

We accept VISA, MasterCard, Discover, American Express and Electronic Checks.

[Payment Inquiry](#) - view information about previously submitted payments.

**All fields must be completed. Please keep in mind that making a false statement in connection with any application for credential is grounds for revocation or denial.**

System maintenance is done between 11:30 pm and 01:30 am everyday. During these times the application will not be available. We apologize for any inconvenience this may cause.

### Step 4

- Carefully read through Step 4 then click continue.

#### Professional Credential Renewal

**Credential Number:** [REDACTED] **Profession:** Medicine and Surgery  
**Renew By:** 10/31/2017 **Renewal Fee:** \$141.00 **Late Fee:**

##### Name/Address Change Information

On the next screen, you will be asked to update your address (where you would like things **Mailed**), name, phone number and email address. Please **ONLY** make changes if the information listed is incorrect. Also, please verify the email address on file is correct.

If you have a name change, you will need to submit **proof** of the name change to the Department including your license/credential number, date of birth and last four (4) digits of your SSN (Social Security Number). Please include a note to change it from **(Old name)** to **(New name)** and include your license number. The proof can be faxed to 608-251-3036 or mailed to the following: DPS - Attn: Renewal, PO Box 8935, Madison, WI 53708-8935.

You will need to enter the last four (4) digits of your FEIN (Federal Employer Identification Number) or SSN if you do not have a FEIN, in order to continue forward with the renewal process.

If you have any questions, you may contact the Department at 608-266-2112 or email to [dps@wisconsin.gov](mailto:dps@wisconsin.gov).

Step 5

- Carefully read through your personal and contact information for accuracy. Please note that any name changes require proof of name change and should be submitted to the department via mail, fax, or email. To continue, enter your last 4 of SSN then click continue.

### Professional Credential Renewal

Make sure the **mailing address for your credential** and your contact information are correct. If any of the fields with a \* are blank you must add the information. Profile updates take 1 business day to process.

**Do not use the back button on your browser.**

Press Continue when finished.

Personal

First Name:  \*

Middle Name:

Last Name:  \*

Gender:  ▼

Date of Birth:  \*  
(mm/dd/yyyy)

Last 4 of SSN:  \*

Contact

Email:  \*

Phone: ()  ext.

Mailing Address

Country:  ▼

Attention:

Address 1:  \*  
Street Address, P.O. Box, etc.

Address 2:   
Apartment, suite, unit, building, floor, etc.

City:  \*

State:  ▼ \*

Zip:  \*

Zip +4:

Step 6

- Carefully read through each affidavit and check that you have read and understand. The last question pertains to any pending charges and/or convictions. Please note that answering Yes to the Conviction Declaration will not complete this requirement. If you have any pending charges and/or convictions you must complete and submit Form #2252 via mail, fax, or email.

**Professional Credential Renewal**

|                               |                                  |
|-------------------------------|----------------------------------|
| Credential Number: [REDACTED] | Profession: Medicine and Surgery |
| Renew By: 10/31/2017          | Renewal Fee: \$141.00 Late Fee:  |

|  |
|--|
| <b>Affidavit of Credential Holder</b>  |
| 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 license/credential or for renewal or reinstatement of a license/credential may result in license/credential application processing delays; denial, revocation, suspension or limitation of my license/credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a license/credential renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority may be cause for disciplinary action. |
| <input type="checkbox"/> I have read and I understand the above affidavit of credential holder statement.  |

|   |
|---|
| <b>Continuing Duty of Disclosure</b>  |
| <b>CONTINUING DUTY OF DISCLOSURE</b>  |
| I understand that I have a continuing duty of disclosure as long as my license/credential is current and valid. If information I have provided becomes invalid, incorrect or outdated, since the last renewal or issuance of my license/credential, I understand that I am obliged to provide any information to ensure the information on file for my license/credential remains current, valid, and truthful. I understand that the Department of Safety and Professional Services may view acts of omission as dishonesty and that my duty of disclosure exists as long as my license/credential is current and valid. |
| <input type="checkbox"/> I have read and I understand the above continuing duty of disclosure statement.  |

|   |
|---|
| <b>Affidavit/Licensee Charges or Convictions</b>  |
| <b>LICENSE/HOLDER CHARGES OR CONVICTIONS</b>  |
| A holder of any of the credentials/licenses set forth in Wis. Stat. s. 440.03(13)(b) who is convicted of a felony or misdemeanor, since the issuance of the license/credential or since the last renewal, in the state or elsewhere shall notify the department in writing of the date, place and nature of the conviction or finding within 48 hours after the entry of the judgment of conviction. Notice shall be made by mail and shall be proven by showing proof of the date of mailing the notice. Notice shall include a copy of the judgment of conviction and a copy of the complaint or other information which describes the nature of the crime and the judgment of conviction in order that the department may determine whether the circumstances of the crime of which the license/credential holder was convicted are substantially related to the practice of the license/credential holder. <u>Form 2250</u> should be completed and submitted to the department along with the associated fees and all requested documents. |
| <input type="checkbox"/> I have read and understand the above statement regarding the responsibility to report any convictions or misdemeanors, since the issuance or last renewal of my license.   |

|  |
|--|
| <b>Conviction Declaration Statement</b>  |
| Since your initial licensure or last renewal, do you have any pending charges and/or have you been convicted of any crimes (does not include minor traffic violations that do not involve alcohol or drugs, such as speeding, running stoplights, and seat belt violations). |
| <input type="radio"/> Yes  |
| <input type="radio"/> No   |

Continue

**Step 7**

- Carefully read the legal status and check to continue. Please note that a change in legal status should be reported when your SSN, Name, or Address have changed since your last renewal.

**Professional Credential Renewal**

|                                      |   |
|--------------------------------------|---|
| <b>Credential Number:</b> ██████████ | <b>Profession:</b> Medicine and Surgery       |
| <b>Renew By:</b> 10/31/2017          | <b>Renewal Fee:</b> \$141.00 <b>Late Fee:</b> |

|  |
|--|
| <b>Legal Status</b>  |
| If your legal status as a qualified alien or nonimmigrant lawfully present in the United States has changed since the issuance of your credential or your last renewal, please contact the Wisconsin Department of Safety and Professional Services at 608-266-2112 or <a href="mailto:dps@wisconsin.gov">dps@wisconsin.gov</a> . I have read and acknowledge this information. <input type="checkbox"/> |

**Step 8**

- Please select all specialties that currently apply to your credential excluding disabled specialties.

**Professional Credential Renewal**

|                                      |   |
|--------------------------------------|---|
| <b>Credential Number:</b> ██████████ | <b>Profession:</b> Medicine and Surgery       |
| <b>Renew By:</b> 10/31/2017          | <b>Renewal Fee:</b> \$141.00 <b>Late Fee:</b> |

|  |
|--|
| <b>Specialties</b>   |
| Please select all specialties that currently apply.<br>Disabled specialties may only be selected at time of initial application. |
| <input type="checkbox"/> ACADEMIC MEDICINE   |
| <input type="checkbox"/> ADMINISTRATIVE MEDICINE   |
| <input type="checkbox"/> AEROSPACE MEDICINE  |
| <input type="checkbox"/> ALCOHOLISM - CHEMICAL DEPENDENCY  |
| <input type="checkbox"/> ALLERGY - IMMUNOLOGY  |
| <input type="checkbox"/> ANESTHESIOLOGY  |
| <input type="checkbox"/> AVIATION MEDICINE   |
| <input type="checkbox"/> DERMATOLOGY   |
| <input type="checkbox"/> EMERGENCY MEDICINE  |
| <input type="checkbox"/> ENDOCRINOLOGY   |
| <input type="checkbox"/> FAMILY PRACTICE   |

**Step 9**

- Carefully read through Step 9 then click continue.

**Professional Credential Renewal**

|                                      |   |
|--------------------------------------|---|
| <b>Credential Number:</b> ██████████ | <b>Profession:</b> Medicine and Surgery       |
| <b>Renew By:</b> 10/31/2017          | <b>Renewal Fee:</b> \$141.00 <b>Late Fee:</b> |

**Continuing Education Audit**

The Medical Examining Board will conduct a Continuing Education compliance audit for Medicine and Surgery (MD) for the most recent biennium. Audit letters will be sent to randomly selected MD license/credential holders beginning in March 2018 in order to verify that 30 hours of AMA or AOA category I continuing education with two of the hours via a Board-approved course on responsible opioid prescription was completed by the randomly selected licensed MDs before December 31, 2017. License/credential holders selected for the audit will be notified in the audit notification letter that they must submit certificates of attendance to the Department verifying that they have completed the 30 required hours of continuing education. If your address on file is not current, you are encouraged to send notice of the address update to the Renewal Unit prior to December 31, 2017.

Continue

**Step 10**

- Carefully read the statement of continuing education then check to continue. Please note that you must check to continue and checking is considered an attestation to completing the continuing education by 12/31/2017.

**Professional Credential Renewal**

|                                      |   |
|--------------------------------------|---|
| <b>Credential Number:</b> ██████████ | <b>Profession:</b> Medicine and Surgery       |
| <b>Renew By:</b> 10/31/2017          | <b>Renewal Fee:</b> \$141.00 <b>Late Fee:</b> |

I have completed or will complete 30 hours\* of AMA or AOA Category I Continuing Education, including two (2) hours of a Board-approved course related to the Board's Opioid Prescribing Guidelines, pursuant to Wis. Admin. Code ch. Med 13.04\*\* I will furnish evidence of completion to the Medical Examining Board upon request.

\*Three (3) months of approved post-graduate training is equivalent to 30 hours of Category I credits. Wis. Admin. Code ch. Med 13.04.

\*\*Pursuant to Wis. Admin. Code ch. Med 13.02(1g)(b), physicians that do **NOT** hold a U.S. Drug Enforcement Administration number to prescribe controlled substances are **NOT** required to complete two (2) hours of a Board-approved course relating to the Board's Opioid Prescribing Guidelines.

Continue

**Step 11**

- Read and check if you would like to serve as an expert witness. Please note if you do not want to serve as an expert witness, you may click continue without checking the box.

**Professional Credential Renewal**

|                                      |   |
|--------------------------------------|---|
| <b>Credential Number:</b> ██████████ | <b>Profession:</b> Medicine and Surgery       |
| <b>Renew By:</b> 10/31/2017          | <b>Renewal Fee:</b> \$141.00 <b>Late Fee:</b> |

|  |
|--|
| <b>Expert Witness</b>  |
| <input type="checkbox"/> Please check here if you are willing to serve as an expert witness in disciplinary proceedings. |

**Step 12**

- Read and check if you would like to opt-out of disclosing your street address on any list requests of ten or more licensees provided by the department.

**Professional Credential Renewal**

|                                      |   |
|--------------------------------------|---|
| <b>Credential Number:</b> ██████████ | <b>Profession:</b> Medicine and Surgery       |
| <b>Renew By:</b> 10/31/2017          | <b>Renewal Fee:</b> \$141.00 <b>Late Fee:</b> |

|   |
|---|
| <b>List Opt-Out</b>   |
| Per Wis. Stat. § 440.14, if you are an individual or a sole proprietor, you may declare that your street address and/or PO Box # not be disclosed on any list of ten or more credential holders that the department furnishes to another person. Please check the box below to make this declaration. |
| <input type="checkbox"/> <b>Please do not disclose my street address and/or PO Box # on lists</b>   |

**Step 13**

- Please read carefully and continue to the US Bank payment page to pay your renewal fee.