Wisconsin Department of Safety and Professional Services
Division of Policy Development
4822 Madison Yards Way
PO Box 8366
Madison WI 53705-8366

Phone: 608-266-2112
Web: http://dsps.wi.gov
Email: dsps@wisconsin.gov

Tony Evers, Governor
Dawn B. Crim, Secretary

LICENSURE FORMS COMMITTEE
MEDICAL EXAMINING BOARD
Room N208, 4822 Madison Yards Way, Madison
Contact: Valerie Payne (608) 266-2112
November 20, 2019

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. Approval of Minutes of September 18, 2019 (2)

C. Administrative Updates
1. Department, Staff, and Board Updates

D. APPEARANCE – Michael Berndt: Review of Application and Renewal Forms – Discussion and Consideration (3-37)
1. Physician Initial Application
2. Physician Renewal Application

E. Next Steps

F. 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 committee's agenda, please call the listed contact person. The committee 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

LICENSURE FORMS COMMITEE
MEDICAL EXAMINING BOARD
MEETING MINUTES
SEPTEMBER 18, 2019

PRESENT: David Bryce, M.D.; Padmaja Doniparthi, M.D.; Bradley Kudick; Lee Ann Lau, M.D.; David Roelke, M.D.

STAFF: Yolanda McGowan, DPD Division Administrator; Michael Berndt, Attorney Supervisor; Megan Glaeser, Bureau Assistant; and other Department staff

CALL TO ORDER

Lee Ann Lau, Chairperson, called the meeting to order at 10:22 a.m. A quorum of five (5) members was confirmed.

ADOPTION OF AGENDA

MOTION: Lee Ann Lau moved, seconded by Padmaja Doniparthi, to adopt the agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES OF AUGUST 21, 2019

MOTION: Lee Ann Lau moved, seconded by David Roelke, to adopt the minutes of August 21, 2019 as published. Motion carried unanimously.

REVIEW OF APPLICATION AND RENEWAL FORMS

MOTION: David Roelke moved, seconded by Padmaja Doniparthi, to refer the recommended changes to the initial and renewal applications for licensure to the Medical Examining Board for consideration. Motion carried unanimously.

ADJOURNMENT

MOTION: Lee Ann Lau moved, seconded by David Bryce, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 11:25 a. m.

DRAFT

Summary of Changes

Renewal Form

1. Paragraph beginning "If you do not have a Social Security Number on file with us. . ." (Blue highlighted text) - Mike Berndt reviewing wording as it does not matter is visa type changes. It would only matter is visa lapses/expires.
2. Paragraph beginning "The Board recognizes that licensees encounter. . ." (Yellow highlighted text) – "he/she" changed to "the applicant."
3. Table – Question 7 (Yellow highlighted text) "or privileges" inserted per Board request.
4. Form 2829 provided for reference as it was included previously.

Form 570, APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY

1. Zack Hendrickson mark-ups accepted – Copy of prior markups provided which includes question renumbering between marked up copy and new draft form.
2. All pages, revision date in lower left changed to "11/19"
3. Page ii under "National Practitioner Data Bank" (Yellow highlighted text) – Fax number updated.
4. Grid on pages 2-3 of 6 – "Type" column updated per Board request (Post Grad checkbox removed and all checkboxes flush)
5. Page 4 of 6, Question 7 (Yellow highlighted text) "privileges" inserted per Board request.
6. WI Admin Chapter Med 1.06(8): "*Has been diagnosed as suffering from pedophilia, exhibitionism or voyeurism.*"

Form 2862, APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY FOR INDIVIDUALS WITH A CURRENT UNRESTRICTED MINNESOTA LICENSE

- Incorporated changes for Form 570 into Form 2862

Wisconsin Dept. of Safety & Professional Services
Professional Credential Processing - Renewal Unit
PO Box 8935
Madison, WI 53708-8935
ADDRESS SERVICE REQUESTED

Office: 4822 Madison Yards Way
Email: dsps@wi.gov
Phone: 608-266-2112
FAX: 608-251-3036
Web: http://dsps.wi.gov
TRS: 800-947-3529

State of Wisconsin
Department of Safety and Professional Services

XXXXX - 020

MEDICINE AND SURGERY RENEWAL

MARY SMITH, MD
MARY SMITH
123 HAPPY VALLEY RD
HOMETOWN, WI 50000

Credential Renewal Fee Schedule:

due before 11/1/2019

Total Owed: $100.00
Total Paid: $0.00
Balance Owed: $100.00

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.
- 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 "Self Service."

- 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

020R6/19CH.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:
45009 - 020	EXPIRED	$100.00	10/31/2019	X3KPC3

AMT PD. $ ____ . __

☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER

CARD # : _____

EXP. DATE: _____

SIGNATURE: _____

PLEASE PRINT NAME/ADDRESS CHANGES IN THE SPACE BELOW

MARY SMITH, MD
MARY SMITH
123 HAPPY VALLEY RD
HOMETOWN, WI 50000
email.address@email.com

☐ 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

020004500900007500001000002

Additional Requirements for Renewal

- Review the Certificate of Legal Status statement below.
- Complete the Continuing Education (CE) Statement below.
- Answer, sign and date the Conviction Statement below.

IMPORTANT NOTICE:

- If you do not renew your license/credential before 11/1/2019, 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.

020R6/19CH.440 XXXXX-20

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 dsps@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 last renewal *or* initial licensure *(*if this is your first renewal), do you have any pending charges, and/or have you violated any federal or state laws, or any local ordinances (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_____

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

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech and hearing impairments, Cerebral Palsy, epilepsy, Muscular Dystrophy, Multiple Sclerosis, cancer, heart disease, Diabetes, 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.

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

1.	Do you have a medical, physical or mental condition, which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If no, you may skip questions 17. **If yes, please explain.**	☐ Yes ☐ No
2.	If yes to question 1, are the limitations or impairments caused by your medical, physical or mental condition reduced or ameliorated because you receive ongoing treatment (with or without medications), participate in a monitoring program or reduced or ameliorated because of the field of practice , the setting, or the manner in which you have chosen to practice? **If yes, please explain.**	☐ Yes ☐ No
3.	Do you use chemical substance(s), as defined above, that in any way impair, or limit your ability to practice medicine with reasonable skill and safety? **If yes, please explain.**	☐ Yes ☐ No
4.	Are you currently (within the last two years) engaged in the illegal use of controlled dangerous substances?	☐ Yes ☐ No
5.	If yes to question 4, are you participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain.**	☐ Yes ☐ No
6.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **If yes, please explain.**	☐ Yes ☐ No
7.	Since your last renewal ***or*** initial licensure (if this is your first renewal), have you been reprimanded, demoted, disciplined, cautioned, placed on probation, limited in your practice or privileges, placed on or taken leave (except vacation), or terminated by any employer, educational institution, training program, licensing board, hospital, medical facility, professional society, specialty board, or medical body for any reason? **If yes, attach a sheet providing details about the action, including the name of the entity and date of action.**	☐ Yes ☐ No
8.	Is disciplinary action pending against you in any jurisdiction**? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	☐ Yes ☐ No

9.	Since your last renewal ***or*** initial licensure (if this is your first renewal), has the Drug Enforcement Administration withdrawn your DEA number or warned you, or have you been denied a DEA number? **If yes, give details on an attached sheet.**	☐ Yes ☐ No
10.	Since your last renewal ***or*** initial licensure (if this is your first renewal), have there been any medical malpractice claims resulting in payouts made on your behalf? **If yes, please submit Malpractice Suits or Claims (Form #2829).**	☐ Yes ☐ No

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.

PENDING CHARGES/CONVICTIONS

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. Form 2252 should be completed and submitted to the department along with the associated fees and all requested documents.

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) 251-3036
Phone #: (608) 266-2112

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

DIVISION OF PROFESSIONAL CREDENTIALING PROCESSING

MALPRACTICE SUITS OR CLAIMS FORM

This form must be completed in its entirety by the licensure applicant.

APPLICANT INFORMATION: (required)

Name of Applicant:

Application ID# Number: (if applicable)

Profession Applying For:

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 for disciplinary action.

Applicant Signature:

Date: / /

List all malpractice suits, claims, or settlements in which you were involved. Provide a brief description of the allegations and final disposition. For any malpractice suits resolved within the past ten (10) years, provide copies of claims/suits, final settlements, dispositions, or dismissed information. **(Continue on page two and/or attach additional sheets if necessary.)**

Parties:

Date Filed: / / **Date Resolved:** / /

Court and Case No. **Disposition:**

Description of Legal Action or Claim:

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Safety and Professional Services

Parties:

Date Filed: __/__/____ **Date Resolved:** __/__/____

Court and Case No. _____ **Disposition:**

Description of Legal Action or Claim:

Parties:

Date Filed: __/__/____ **Date Resolved:** __/__/____

Court and Case No. _____ **Disposition:**

Description of Legal Action or Claim:

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Madison, WI 53708-8935
FAX #: (608) 251-3036
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Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

INFORMATION FOR COMPLETING 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.

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

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Safety and Professional Services

ENDORSEMENT OF FLEX AND/OR USMLE EXAM SCORES:

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

ENDORSEMENT OF NATIONAL BOARDS:

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

ENDORSEMENT OF NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS CERTIFICATION:

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

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

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

RECIPROCITY OF ANOTHER STATE BOARD EXAM TAKEN PRIOR TO 1972:

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

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 or faxed to (608) 251-3036. 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.

ORAL EXAMS:

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

FOREIGN GRADUATES:

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

VISITING PHYSICIAN:

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

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

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

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

ADMINISTRATIVE PHYSICIAN:

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

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

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

Wisconsin Department of Safety and Professional Services

CODES FOR SPECIALTIES:

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

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

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
Website: http://dsps.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)**

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __ / __ / ____

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.

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)

Medical School

Medical School Address (street, city, state)

Degree

Date Degree Granted __ / __ / ____

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**

☐ **I am seeking a Veteran Fee Waiver**
(for Initial Credential Fee only, see page 2 for further information)

☐ **Endorsement of Steps 1, 2 and 3 of USMLE**
$75.00 Initial Credential Fee
$75.00 Total Fee Attached

☐ **Endorsement of National Boards (MD or DO), (NBME or NBOME)**
$75.00 Initial Credential Fee
$75.00 Total Fee Attached

☐ **Endorsement of FLEX**
$75.00 Initial Credential Fee
$75.00 Total Fee Attached

☐ **Endorsement of LMCC(taken after 1/1/78)**
$75.00 Initial Credential Fee
$75.00 Total Fee Attached

☐ **Reciprocity of State Board Exam (Taken Prior to 1972)**
$141.00 Reciprocal Credential Fee
$141.00 Total Fee Attached

☐ **Visiting Physician**
$141.00 Reciprocal Credential Fee
$141.00 Total Fee Attached

☐ **Re-Registration** (license expired more than 5 years)
$141.00 Renewal Fee
$ 25.00 Late Renewal Fee
$166.00 Total Fee Attached

For Receipting 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 https://dsps.wi.gov/Pages/Professions/MilitaryLicensureBenefits.aspx for eligibility requirements.

If you qualify, are you requesting a waiver of your initial credentialing fee? ☐ Yes ☐ No

If Yes, provide a copy of your Department of Veterans Affairs voucher code and list your DVA Voucher Code Number: _____

If you qualify, are you requesting equivalency of your Military Training and experience? ☐ Yes ☐ No
If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

If you qualify, are you requesting Temporary Spousal Reciprocal License? ☐ Yes ☐ No

If Yes, do not complete this form. You must complete and return the Application for Temporary Spousal Reciprocal License (**Form #2982**).

You may contact the DVA at 1-800-WisVets or www.WISVETS.com **for assistance in obtaining your DVA Voucher Code and/or documents related to your training.**

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

POST-GRADUATE TRAINING/FELLOWSHIPS, PRACTICE, AND OTHER ACTIVITIES: List in chronological order from the date of graduation of medical school to the present time. The below information **must include professional and nonprofessional activities. (Attach additional sheets if necessary using the same format.)**

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

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

DATES (Month, Year)	**TYPE**	**NAME OF SCHOOL, HOSPITAL CLINIC OR OTHER**	**LOCATION** (City, State and Country)
(From) ___ / ___ (To) ___ / ___	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) ___ / ___ (To) ___ / ___	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) ___ / ___ (To) ___ / ___	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)

Wisconsin Department of Safety and Professional Services

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

DATES (Month, Year)	**TYPE**	**NAME OF SCHOOL, HOSPITAL CLINIC OR OTHER**	**LOCATION** (City, State and Country)
(From) ___ / ___ (To) ___ / ___	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) ___ / ___ (To) ___ / ___	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) ___ / ___ (To) ___ / ___	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) ___ / ___ (To) ___ / ___	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) ___ / ___ (To) ___ / ___	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) ___ / ___ (To) ___ / ___	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) ___ / ___ (To) ___ / ___	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)

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

For each credential listed above, you are required to have each State Board or territory of the United States submit a letter of verification to the Wisconsin Medical Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

Wisconsin Department of Safety and Professional Services

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

1.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):**	☐ Yes ☐ No
2.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under:**	☐ Yes ☐ No
3.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases? https://docs.legis.wisconsin.gov/code/admin_code/dhs/110/145 https://docs.legis.wisconsin.gov/statutes/statutes/252	☐ Yes ☐ No
4.	Have you ever failed to pass any state board examination, national board examination (NBME or NBOME), FLEX, or USMLE examination? **If yes, provide details below:**	☐ Yes ☐ No
5.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	☐ Yes ☐ No
6.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	☐ Yes ☐ No
7.	Have you ever been reprimanded, demoted, disciplined, cautioned, placed on probation, limited in your practice or privileges, placed on or take leave (except vacation) or terminated by any employer, educational institution, training program, licensing board, hospital, medical facility, professional society, specialty board, or medical body for any reason? **If yes, attach a sheet providing details about the action, including the name of the entity and date of action.**	☐ Yes ☐ No
8.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, Malpractice Suits or Claims (Form #2829).**	☐ Yes ☐ No
9.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? **If yes, give details on an attached sheet.**	☐ Yes ☐ No
10.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea or verdict. **If yes, submit Convictions and Pending Charges (Form #2252).**	☐ Yes ☐ No
11.	Are you incarcerated, on probation, or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	☐ Yes ☐ No
12.	If yes to question 10 above, did you apply for a predetermination of the convictions? **If YES, proceed to question 13.** **If NO, submit Convictions and Pending Charges Form #2252 and supporting documentation.**	☐ Yes ☐ No
13.	If yes to question 12, did you receive an approval letter? **If YES, proceed to question 14.** **If NO, submit Convictions and Pending Charges Form #2252 and supporting documentation.**	☐ Yes ☐ No
14.	If yes to question 14, **since the date of your approval letter** have you been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. **If YES, submit Convictions and Pending Charges Form #2252 and supporting documentation.** **If NO, do not submit Convictions and Pending Charges Form #2252.**	☐ Yes ☐ 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)

15.	Do you have a medical, physical or mental condition, which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If no, you may skip questions 17. **If yes, please explain.**	☐ Yes ☐ No
16.	If yes to question 15, are the limitations or impairments caused by your medical, physical or mental condition reduced or ameliorated because you receive ongoing treatment (with or without medications), participate in a monitoring program or reduced or ameliorated because of the field of practice , the setting, or the manner in which you have chosen to practice? **If yes, please explain.**	☐ Yes ☐ No
17.	Do you use chemical substance(s), as defined above, that in any way impair, or limit your ability to practice medicine with reasonable skill and safety? **If yes, please explain.**	☐ Yes ☐ No
18.	Are you currently (within the last two years) engaged in the illegal use of controlled dangerous substances?	☐ Yes ☐ No
19.	If yes to question 18, are you participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **If yes, please explain.**	☐ Yes ☐ No
20.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **If yes, please explain.**	☐ Yes ☐ No

CERTIFICATION OF LEGAL STATUS:

I declare under penalty of law that I am (check one):

☐ A citizen or national of the United States, or

☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

Wisconsin Department of Safety and Professional Services

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature: _____ Date: __ __ / __ __ / __ __ __ __

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Office Location: 4822 Madison Yards Way
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E-Mail: 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.

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. NBME will forward this information directly to the Department.

ENDORSEMENT OF NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS CERTIFICATION:

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

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

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

RECIPROCITY OF ANOTHER STATE BOARD EXAM TAKEN PRIOR TO 1972:

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

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 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.

Wisconsin Department of Safety and Professional Services

ORAL EXAMS:

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

FOREIGN GRADUATES:

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

VISITING PHYSICIAN:

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

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

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

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

ADMINISTRATIVE PHYSICIAN:

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

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

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

Wisconsin Department of Safety and Professional Services

CODES FOR SPECIALTIES:

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

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

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
Website: http://dsps.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)**

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __ / __ / ____

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.

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)

Medical School

Medical School Address (street, city, state)

Degree

Date Degree Granted __ / __ / ____

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**

☐ **I am seeking a Veteran Fee Waiver** (for Initial Credential Fee only, see page 2 for further information)

☐ **Endorsement of Steps 1, 2 and 3 of USMLE**
$75.00 Initial Credential Fee
$75.00 Total Fee Attached

☐ **Endorsement of National Boards (MD or DO), (NBME or NBOME)**
$75.00 Initial Credential Fee
$75.00 Total Fee Attached

☐ **Endorsement of FLEX**
$75.00 Initial Credential Fee
$75.00 Total Fee Attached

☐ **Endorsement of LMCC(taken after 1/1/78)**
$75.00 Initial Credential Fee
$75.00 Total Fee Attached

☐ **Reciprocity of State Board Exam (Taken Prior to 1972)**
$141.00 Reciprocal Credential Fee
$141.00 Total Fee Attached

☐ **Visiting Physician**
$141.00 Reciprocal Credential Fee
$141.00 Total Fee Attached

☐ **Re-Registration** (license expired more than 5 years)
$141.00 Renewal Fee
$ 25.00 Late Renewal Fee
$166.00 Total Fee Attached

For Receipting 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 https://dsps.wi.gov/Pages/Professions/MilitaryLicensureBenefits.aspx ~~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 **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."~~ https://dsps.wi.gov/Pages/Professions/Physician/Default.aspx

POST-GRADUATE TRAINING/FELLOWSHIPS, PRACTICE, AND OTHER ACTIVITIES: List in chronological order from the date of graduation of medical school to the present time. The below information **must include professional and nonprofessional activities. (Attach additional sheets if necessary using the same format.)**

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

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

DATES (Month, Year)	**TYPE**	**NAME OF SCHOOL, HOSPITAL CLINIC OR OTHER**	**LOCATION** (City, State and Country)
(From) ___/___ (To) ___/___	☐ Post Grad ☐ Intern/Resident ~~☐ Resident~~ ☐ Fellow ☐ Practice ☐ Other		(City) _____ (State) _____ (Country) _____
(From) ___/___ (To) ___/___	☐ Post Grad ☐ Intern/Resident ~~☐ Resident~~ ☐ Fellow ☐ Practice ☐ Other		(City) _____ (State) _____ (Country) _____
(From) ___/___ (To) ___/___	☐ Post Grad ☐ Intern/Resident ~~☐ Resident~~ ☐ Fellow ☐ Practice ☐ Other		(City) _____ (State) _____ (Country) _____

(From) ___/___ (To) ___/___	☐ Post Grad ☐ Intern ☐ Resident ☐ Fellow ☐ Practice ☐ Other		(City) (State) (Country)

#570 (Rev. 17/198)
Ch. 448, Stats.

Committed to Equal Opportunity in Employment and Licensing

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.

DATES (Month, Year)	**TYPE**	**NAME OF SCHOOL, HOSPITAL CLINIC OR OTHER NAME OF HOSPITAL OR CLINIC**	**LOCATION** (City, State and Country)
(From) ___/___ (To) ___/___	☐ Post Grad ☐ Intern/Resident ☐ Fellow ☐ Practice ☐ Other Privilege ☐ Employment ☐ Appointment ☐ Practice ☐ Other		(City) (State) (Country)
(From) ___/___ (To) ___/___	☐ Post Grad ☐ Intern/Resident ☐ Fellow ☐ Practice ☐ Other Privilege ☐ Employment ☐ Appointment ☐ Practice ☐ Other		(City) (State) (Country)
(From) ___/___ (To) ___/___	☐ Post Grad ☐ Intern/Resident ☐ Fellow ☐ Practice ☐ Other Privilege ☐ Employment ☐ Appointment ☐ Practice ☐ Other		(City) (State) (Country)
(From) ___/___ (To) ___/___	☐ Post Grad ☐ Intern/Resident ☐ Fellow ☐ Practice ☐ Other Privilege ☐ Employment ☐ Appointment ☐ Practice ☐ Other		(City) (State) (Country)
(From) ___/___ (To) ___/___	☐ Post Grad ☐ Intern/Resident ☐ Fellow ☐ Practice ☐ Other Privilege		(City) (State) (Country)

	☐~~Employment~~ ☐~~Appointment~~ ☐~~Practice~~ ☐~~Other~~		
(From) ___/___ (To) ___/___	☐Post Grad ☐ Intern/Resident ☐Fellow ☐Practice ☐Other☐ ~~Privilege~~ ☐~~Employment~~ ☐~~Appointment~~ ☐~~Practice~~ ☐~~Other~~		(City) (State) (Country)
(From) ___/___ (To) ___/___	☐Post Grad ☐ Intern/Resident ☐Fellow ☐Practice ☐Other☐ ~~Privilege~~ ☐~~Employment~~ ☐~~Appointment~~ ☐~~Practice~~ ☐~~Other~~		(City) (State) (Country)

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

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.

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Safety and Professional Services

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

~~1~~ 3.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases? https://docs.legis.wisconsin.gov/code/admin_code/dhs/110/145 https://docs.legis.wisconsin.gov/statutes/statutes/252	☐ Yes ☐ No	NEW FORM #3
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	☐ Yes ☐ No	NEW FORM #5
~~3~~ 4.	Have you ever failed to pass any state board examination, national board examination (NBME or NBOME), FLEX, or USMLE examination? **If yes, provide details below:**	☐ Yes ☐ No	NEW FORM #4
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?~~Have you ever been reprimanded, demoted, disciplined, cautioned, placed on probation, limited in your practice, placed on or take leave (except vacation) or terminated by any employer, educational institution, training program, licensing board, hospital, medical facility, professional society, specialty board, or medical body for any reason? **If yes, attach a sheet providing details about the action, including the name of the ~~credentialing agency~~entity and date of action.**	☐ Yes ☐ No	NEW FORM #7
~~5~~ 7.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	☐ Yes ☐ No	NEW FORM #6

116.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea or verdict. **If yes, submit Convictions and Pending Charges (Form #2252).**	☐ Yes ☐ No	NEW FORM #10
127.	Are you incarcerated, on probation, or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	☐ Yes ☐ No	NEW FORM #11
108.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, Malpractice Suits or Claims (Form #2829).**	☐ Yes ☐ No	NEW FORM #8
9.	~~Have your hospital privileges ever been limited or removed? **If yes, give details on an attached sheet.**~~	~~☐ Yes ☐ No~~	—
~~10.~~ 1.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):**	☐ Yes ☐ No	NEW FORM #1
~~11.~~ 2.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under:**	☐ Yes ☐ No	NEW FORM #2
8~~12~~.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? **If yes, give details on an attached sheet.**	☐ Yes ☐ No	NEW FORM #9

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)

13.	Do you have a medical, physical or mental condition, which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If no, you may skip questions 14 ~~and 15~~. **If yes, please explain.**	☐ Yes ☐ No	NEW FORM #15
14.	If yes to question 13, are the limitations or impairments caused by your medical, physical or mental condition reduced or ameliorated because you receive ongoing treatment (with or without medications), ~~or~~ participate in a monitoring program or reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If yes, please explain.**	☐ Yes ☐ No	NEW FORM #16
~~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? **If yes, please explain.**~~	☐ Yes ☐ No	—
16.	Do~~es~~ you~~r~~ use ~~of~~ chemical substance(s), as defined above, that in any way impair, or limit your ability to practice medicine with reasonable skill and safety? **If yes, please explain.**	☐ Yes ☐ No	NEW FORM #17
17.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **If yes, please explain.**	☐ Yes ☐ No	NEW FORM #20
18.	Are you currently (within the last two years) engaged in the illegal use of controlled dangerous substances?	☐ Yes ☐ No	NEW FORM #18

Commented [A1]: Move to last question

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? **If yes, please explain.**	☐ Yes ☐ No
20.	If yes to question 6 above, did you apply for a predetermination of the convictions? **If YES, proceed to question 21.** **If NO, submit Convictions and Pending Charges Form #2252 and supporting documentation.**	☐ Yes ☐ No
21.	If yes to question 20, did you receive an approval letter? **If YES, proceed to question 22.** **If NO, submit Convictions and Pending Charges Form #2252 and supporting documentation.**	☐ Yes ☐ No
22.	If yes to question 21, **since the date of your approval letter** have you been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. **If YES, submit Convictions and Pending Charges Form #2252 and supporting documentation.** **If NO, do not submit Convictions and Pending Charges Form #2252.**	☐ Yes ☐ No

NEW FORM #19

NEW FORM #12

Formatted Table

NEW FORM #13

NEW FORM #14

Commented [A2]: Questions 20-22 are being added to all applications due to 2017 Wisconsin Act 278.

Commented [A3]: Move questions 20-21 near the original conviction question.

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

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E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

INFORMATION FOR COMPLETING APPLICATION FOR MEDICINE AND SURGERY FOR INDIVIDUALSWITH 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, 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.DOProfiles.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
4822 MADISON YARDS WAY
MADISON WI 53705

Wisconsin Department of Safety and Professional Services

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

Academic Medicine	37
Administrative Medicine	71
Aerospace Medicine	33
Alcoholism - Chemical Dependency	49
Allergy - Immunology	01
Anesthesiology	02
Aviation Medicine	32
Dermatology	03
Emergency Medicine	31
Endocrinology	56
Family Practice	41
Gastroenterology	06
General Practice	08
Genetics	61
Geriatrics	29
Hand Surgery	64
Hebiatrics	46
Hematology	07
Hyperbaric Medicine	65
Immunology - Infectious Diseases	47
Institutional Medicine	39
Internal Medicine	04
Internal Medicine - Cardiology	05
Internal Medicine - Pulmonary Medicine	45
Neonatology	63
Nephrology	40
Neurology	10
Neurophysiology	51
Nuclear Medicine	23
Obstetrics and Gynecology	12
Occupational Medicine	30
Oncology	38
Ophthalmology	13
Orthopedic Surgery	14
Otolaryngology	67
Otorhinolaryngology - Ent	15
Pain	66
Pathology	16
Pathology - Clinical	17
Pathology - Surgical Anatomic	72
Pediatrics	18
Pediatrics - Other	60
Perinatology	62
Pharmacology - Clinical	48
Physical Medicine and Rehabilitation	19
Preventive Medicine	09
Proctology	36
Psychiatry	20
Psychiatry - Child	21
Public Health	22
Radiation - Oncology	70
Radiology	53
Radiology - Diagnostic	43
Radiology - Nuclear Medicine	68
Radiology - Ultrasound	69
Research	34
Retired	24
Rheumatology	57
School Physician	52
Surgery - Cardiovascular	44
Surgery - Colon and Rectal	54
Surgery - General	25
Surgery - Maxillofacial	58
Surgery - Neurological	11
Surgery - Peripheral Vascular	59
Surgery - Plastic	26
Surgery - Thoracic	27
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).

Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __ / __ / ____

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.

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

Medical School Name

Medical School Address (street, city, state)

Date Degree Granted __ / __ / ____

Degree

Specialty (see page iii for a listing of codes)

Specialty Code

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**
$ 75.00 Reciprocal Initial Credential Fee
$ 75.00 Total Fee Attached

For Receipting 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 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 (Month/Year)	**Type**	**Name of School, Hospital Clinic, or Other**	**Location** (City, State and Country)
(From) __ __ / __ __ (To) __ __ / __ __	☐ Post-Grad ☐ Intern ☐ Resident ☐ Fellow		(City) (State) (Country)
(From) __ __ / __ __ (To) __ __ / __ __	☐ Post-Grad ☐ Intern ☐ Resident ☐ Fellow		(City) (State) (Country)
(From) __ __ / __ __ (To) __ __ / __ __	☐ Post-Grad ☐ Intern ☐ Resident ☐ Fellow		(City) (State) (Country)

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?	☐ Yes ☐ No
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license, or other credential in Wisconsin, or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	☐ Yes ☐ No
3.	Have you ever failed to pass any state board examination, national board (NBME or NBOME), FLEX, or, USMLE examination? **If yes, provide details below:**	☐ Yes ☐ 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? **If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.**	☐ Yes ☐ No
5.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	☐ Yes ☐ 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? **If yes, submit Convictions and Pending Charges (Form #2252).**	☐ Yes ☐ No
7.	Are you incarcerated, on probation, or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	☐ Yes ☐ No
8.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition and complete Malpractice Suits or Claims (Form #2829).**	☐ Yes ☐ No
9.	Have your hospital privileges ever been limited or removed? **If yes, please explain.**	☐ Yes ☐ No
10.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):**	☐ Yes ☐ No
11.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under:**	☐ Yes ☐ No
12.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? **If yes, give details on an attached sheet.**	☐ Yes ☐ 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.

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? **If yes, please explain**.	☐ Yes ☐ 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? **If yes, please explain**.	☐ Yes ☐ 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? **If yes, please explain**.	☐ Yes ☐ 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? **If yes, please explain**.	☐ Yes ☐ No
15.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **If yes, please explain**.	☐ Yes ☐ No
16.	Are you currently engaged in the illegal use of controlled dangerous substances?	☐ Yes ☐ 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? **If yes, please explain**.	☐ Yes ☐ 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: __ __ / __ __ / __ __ __ __