



MEDICAL EXAMINING BOARD
Virtual, 4822 Madison Yards Way, Madison
Contact: Valerie Payne (608) 266-2112
June 17, 2020

The following agenda describes the issues that the Board 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 Board.

AGENDA

8:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

A. Adoption of Agenda (1-5)

B. Approval of Minutes of May 20, 2020 (6-14)

C. Introductions, Announcements and Recognition

D. Conflicts of Interest

E. Administrative Matters

- 1) Board, Department and Staff Updates
- 2) Election of Officers, Appointment of Liaisons
- 3) Board Members – Term Expiration Dates
 - a. Alaa Abd-Elsayed – 7/1/2020
 - b. Milton Bond, Jr. – 7/1/2023
 - c. David A. Bryce – 7/1/2021
 - d. Michael Carton – 7/1/2020
 - e. Clarence Chou – 7/1/2023
 - f. Padmaja Doniparthi – 7/1/2021
 - g. Sumeet Goel – 7/1/2023
 - h. Bradley Kudick – 7/1/2020
 - i. Michael Parish – 7/1/2023
 - j. David Roelke – 7/1/2021
 - k. Sheldon Wasserman – 7/1/2023
 - l. Timothy Westlake – 7/1/2020
- 4) Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
- 5) Screening Panel and Examination Panel Appointments
- 6) Wis. Stat. § 15.085 (3)(b) – Affiliated Credentialing Boards’ Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest

F. Legislative and Policy Matters – Discussion and Consideration

- G. Administrative Rule Matters – Discussion and Consideration**
 - 1) Pending or Possible Rulemaking Projects
- H. Medical Examining Board Licensure Forms Committee – Discussion and Consideration**
 - 1) Review of Other Licenses Under Jurisdiction (**15-65**)
- I. Discretions in Emergency Orders Written for Physician Assistants and Nurse Practitioners – Discussion and Consideration**
- J. COVID-19 – Discussion and Consideration**
- K. CE Broker – Discussion and Consideration**
- L. Federation of State Medical Boards (FSMB) Matters – Discussion and Consideration
- M. Controlled Substances Board Report – Timothy Westlake
- N. Interstate Medical Licensure Compact Commission (IMLCC) – Report from Wisconsin’s Commissioners
- O. Newsletter Matters – Discussion and Consideration
- P. Screening Panel Report
- Q. Future Agenda Items
- R. Discussion and Consideration of Items Added After Preparation of Agenda:
 - 1) Introductions, Announcements and Recognition
 - 2) Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
 - 3) Administrative Matters
 - 4) Election of Officers
 - 5) Appointment of Liaisons and Alternates
 - 6) Delegation of Authorities
 - 7) Education and Examination Matters
 - 8) Credentialing Matters
 - 9) Practice Matters
 - 10) Legislative and Policy Matters
 - 11) Administrative Rule Matters
 - 12) Liaison Reports
 - 13) Board Liaison Training and Appointment of Mentors
 - 14) Informational Items
 - 15) Division of Legal Services and Compliance (DLSC) Matters
 - 16) Presentations of Petitions for Summary Suspension
 - 17) Petitions for Designation of Hearing Examiner
 - 18) Presentation of Stipulations, Final Decisions and Orders
 - 19) Presentation of Proposed Final Decisions and Orders
 - 20) Presentation of Interim Orders
 - 21) Petitions for Re-Hearing
 - 22) Petitions for Assessments
 - 23) Petitions to Vacate Orders
 - 24) Requests for Disciplinary Proceeding Presentations
 - 25) Motions

- 26) Petitions
- 27) Appearances from Requests Received or Renewed
- 28) Speaking Engagements, Travel, or Public Relation Requests, and Reports

S. Public Comments

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85(1)(b), and 448.02(8), Stats.); to consider individual histories or disciplinary data (s. 19.85(1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.).

T. Credentialing Matters

- 1) **8:45 A.M. APPEARANCE: Full Board Oral Examination**
 - a. Hassan Kieso **(66-281)**
- 2) **Waiver of Post-Graduate Training & Limited Privileges**
 - a. Ashwin Pimpalwar **(282-390)**

U. Deliberation on DLSC Matters

- 1) **Deliberation on Petition for Authorization to Request Extension of Time**
 - a. 19 MED 198 – L.F.B. **(391-395)**
- 2) **Stipulations and Final Decisions and Orders**
 - a. 17 MED 429 – Jose Boggio, M.D. **(396-401)**
 - b. 18 MED 177 – Thomas P. Lyngholm, M.D. **(402-407)**
 - c. 18 MED 650 – Frances S. Madden, M.D. **(408-414)**
- 3) **Administrative Warnings**
 - a. 18 MED 658 – M.E.B. **(414-415)**
 - b. 19 MED 140 – A.C.R. **(416-417)**
 - c. 19 MED 311 – R.D.A. **(418-419)**
- 4) **Case Closings**
 - a. 18 MED 010 – G.W.C. **(420-426)**
 - b. 18 MED 126 – D.K. **(427-439)**
 - c. 18 MED 261 – J.S.S. **(440-446)**
 - d. 18 MED 344 – J.B. **(447-449)**
 - e. 18 MED 346 – R.B. **(450-452)**
 - f. 18 MED 358 – R.C. **(453-455)**
 - g. 18 MED 367 – J.D. **(456-458)**
 - h. 18 MED 368 – J.E. **(459-461)**
 - i. 18 MED 420 – J.H. **(462-464)**
 - j. 18 MED 426 – T.J. **(465-467)**
 - k. 18 MED 506 – A.G.R. **(468-470)**
 - l. 18 MED 507 – A.R. **(471-473)**
 - m. 18 MED 514 – K.S. **(474-476)**
 - n. 18 MED 515 – M.S.T. **(477-479)**
 - o. 18 MED 532 – C.S. **(480-482)**
 - p. 18 MED 542 – N.S. **(483-485)**
 - q. 18 MED 556 – J.S. **(486-488)**

- r. 18 MED 575 – G.W. **(489-491)**
- s. 18 MED 578 – T.W. **(492-494)**
- t. 18 MED 682 – J.M. **(495-507)**
- u. 19 MED 120 – E.C. **(508-524)**
- v. 19 MED 160 – R.L. **(525-533)**
- w. 19 MED 198 – L.F.B. **(534-538)**
- x. 19 MED 204 – S.L. **(539-552)**
- y. 19 MED 426 – D.J.C. **(553-560)**
- z. 19 MED 498 – T.J.D. **(561-565)**
- aa. 19 MED 510 – M.F. **(566-580)**
- bb. 19 MED 650 – D.N.S. **(581-583)**

5) Monitoring Matters (584-585)

- a. Thomas Barragry, M.D. – Requesting Surrender of License **(586-600)**
- b. Warren Dunn, M.D. – Requesting Compliance Through TX PHP as Compliance with Order #5959 **(601-631)**
- c. Peter Shearer, A.A. – Requesting Review of Practice Limitations **(632-641)**

V. Deliberation of Items Added After Preparation of the Agenda

- 1) Education and Examination Matters
- 2) Credentialing Matters
- 3) DLSC Matters
- 4) Monitoring Matters
- 5) Professional Assistance Procedure (PAP) Matters
- 6) Petitions for Summary Suspensions
- 7) Petitions for Designation of Hearing Examiner
- 8) Proposed Stipulations, Final Decisions and Order
- 9) Proposed Interim Orders
- 10) Administrative Warnings
- 11) Review of Administrative Warnings
- 12) Proposed Final Decisions and Orders
- 13) Matters Relating to Costs/Orders Fixing Costs
- 14) Complaints
- 15) Case Closings
- 16) Board Liaison Training
- 17) Petitions for Extension of Time
- 18) Petitions for Assessments and Evaluations
- 19) Petitions to Vacate Orders
- 20) Remedial Education Cases
- 21) Motions
- 22) Petitions for Re-Hearing
- 23) Appearances from Requests Received or Renewed

W. Open Cases

X. Consulting with Legal Counsel

- 1) Legal Remedies Regarding Delayed Responses to Requests for Case Information

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

Y. Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate

Z. Open Session Items Noticed Above Not Completed in the Initial Open Session

AA. Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

ADJOURNMENT

ORAL EXAMINATION OF CANDIDATES FOR LICENSURE

ROOM N207

10:00 A.M. OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING

CLOSED SESSION – Reviewing Applications and Conducting Oral Examination of **five (5)** (at time of agenda publication) Candidates for Licensure – **Dr. Roelke** and **Dr. Wasserman**

NEXT DATE: JULY 15, 2020

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. In order to confirm a meeting or to request a complete copy of the board's agenda, please call the listed contact person. The board may also consider materials or items filed after the transmission of this notice. Times listed for the commencement of disciplinary hearings may be changed by the examiner for the convenience of the parties. Interpreters for the hearing impaired provided upon request by contacting the Affirmative Action Officer, 608-266-2112, or the Meeting Staff at 608-266-5439.

**TELECONFERENCE/VIRTUAL
MEDICAL EXAMINING BOARD
MEETING MINUTES
MAY 20, 2020**

PRESENT: Alaa Abd-Elsayed, M.D.; Milton Bond, Jr., David Bryce, M.D; Michael Carton (*joined at 9:08 a.m.*), Padmaja Doniparthi, M.D.; Clarence Chou, M.D.; Sumeet Goel, D.O. (*disconnected at 9:47 a.m.*); Bradley Kudick; Lee Ann Lau, M.D.; Michael Parish, M.D.; David Roelke, M.D.; Sheldon Wasserman, M.D.; Timothy Westlake, M.D.

STAFF: Valerie Payne, Executive Director; Yolanda McGowan, Legal Counsel; Dale Kleven, Rules Coordinator; Megan Glaeser, Bureau Assistant; and other Department staff

CALL TO ORDER

Timothy Westlake, Vice Chairperson, called the meeting to order at 8:08 a.m. A quorum was confirmed with twelve (12) members present.

ADOPTION OF AGENDA

MOTION: David Roelke moved, seconded by Lee Ann Lau, to adopt the Agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES OF APRIL 15, 2020

MOTION: Alaa Abd-Elsayed moved, seconded by David Roelke, to adopt the Minutes of April 15, 2020 published. Motion carried unanimously.

APPROVAL OF MINUTES OF APRIL 15, 2020

Recognition of Kenneth Simons, Physician Member

MOTION: Alaa Abd-Elsayed moved, seconded by Bradley Kudick, recognize and thank Kenneth Simons, M.D. for his years of outstanding service to the Medical Examining Board and the State of Wisconsin. Motion carried unanimously.

ADMINISTRATIVE MATTERS

Election of Officers

Chairperson

NOMINATION: Sheldon Wasserman nominated Timothy Westlake for the Office of Chairperson.

NOMINATION: Lee Ann Lau nominated Timothy Westlake for the Office of Chairperson.

NOMINATION: Alaa Abd-Elsayed nominated Timothy Westlake for the Office of Chairperson.

Valerie Payne, Executive Director, called for nominations three (3) times.

Timothy Westlake was elected as Chairperson by unanimous voice vote.

Vice Chairperson

NOMINATION: Timothy Westlake nominated Sheldon Wasserman for the Office of Vice Chairperson.

NOMINATION: Alaa Abd-Elsayed nominated Sheldon Wasserman for the Office of Vice Chairperson.

NOMINATION: David Bryce nominated Sheldon Wasserman for the Office of Vice Chairperson.

Valerie Payne, Executive Director, called for nominations three (3) times.

Sheldon Wasserman was elected as Vice Chairperson by unanimous voice vote.

Secretary

NOMINATION: Sheldon Wasserman nominated Alaa Abd-Elsayed for the Office of Secretary.

NOMINATION: Clarence Chou nominated Alaa Abd-Elsayed for the Office of Secretary.

NOMINATION: Padmaja Doniparthi nominated Alaa Abd-Elsayed for the Office of Secretary.

Valerie Payne, Executive Director, called for nominations three (3) times.

Alaa Abd-Elsayed was elected as Secretary by unanimous voice vote.

2020 ELECTION RESULTS	
Chairperson	Timothy Westlake
Vice Chairperson	Sheldon Wasserman
Secretary	Alaa Abd-Elsayed

Appointment of Liaisons

2020 LIAISON APPOINTMENTS

Credentialing Liaison(s)	Sumeet Goel, Clarence Chou Alternate: David Roelke, David Bryce
Office of Education and Examinations Liaison(s)	David Roelke Alternate: David A. Bryce
Continuing Education Liaison(s)	David Roelke Alternate: Alaa Abd-Elseyed
Monitoring Liaison(s)	Padmaja Doniparthi Alternate: Clarence Chou
Professional Assistance Procedure (PAP) Liaison(s)	Padmaja Doniparthi Alternate: Alaa Abd-Elseyed
Legislative Liaison	Timothy Westlake, Sheldon Wasserman
Travel Liaison(s)	David Bryce Alternate: Sumeet Goel
Newsletter Liaison(s)	Bradley Kudick Alternate: Michael Carton
Prescription Drug Monitoring Program Liaison(s)	Timothy Westlake Alternate: David Bryce
Website Liaison(s)	Michael Carton Alternate: Milton Bond, Jr.
Administrative Rules Liaison(s)	David Roelke Alternate: Sumeet Goel
Appointed to Controlled Substances Board as per Wis. Stats. §15.405(5g) (MED)	Timothy Westlake
Council on Anesthesiologist Assistants	Padmaja Doniparthi
IMLCC	Sheldon Wasserman

MOTION: Clarence Chou moved, seconded by Bradley Kudick, to appoint Padmaja Doniparthi to the Council on Anesthesiologist Assistants as the Medical Examining Board representative. Motion carried unanimously.

LEGISLATION AND POLICY MATTERS

2019 Senate Bill 399, Relating to Temporary Practice by Physicians at Camps, Providing an Exemption from Emergency Rule Procedures, and Granting Rule-Making Authority

MOTION: Lee Ann Lau moved, seconded by Sheldon Wasserman, to rescind the Board's opposition to 2019 Senate Bill 399. Motion carried unanimously.

ADMINISTRATIVE RULE MATTERS

Limited License for Disasters and Emergencies for Physicians and Physician Assistants

MOTION: David Roelke moved, seconded by Lee Ann Lau, to direct DSPP Staff to research options for emergency temporary licensure under extraordinary situations and bring the matter back for discussion at its next regularly scheduled meeting. Motion carried unanimously.

(Michael Carton joined the meeting at 9:08 a.m.)

(Sumeet Goel disconnected at 9:47 a.m.)

CLOSED SESSION

MOTION: Clarence Chou moved, seconded by Bradley Kudick, to convene to Closed Session to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). Timothy Westlake, the Chairperson, read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Alaa Abd-Elseyed-yes; Milton Bond, Jr.-yes; David Bryce-yes; Michael Carton-yes; Clarence Chou-yes; Padmaja Doniparthi-yes; Bradley Kudick-yes; Lee Ann Lau-yes; Michael Parish-yes; David Roelke-yes; Sheldon Wasserman-yes; and Timothy Westlake-yes. Motion carried unanimously.

The Board convened into Closed Session at 9:59 a.m.

CREDENTIALING MATTERS

Waiver of Post-Graduate Training

Kikap Kim

MOTION: David Roelke moved, seconded by Sheldon Wasserman, to approve the Waiver of 24-Month Post-Graduate Training application of Kikap Kim, once all requirements are met. Motion carried unanimously.

Vijay Eyunni

MOTION: Lee Ann Lau moved, seconded by Bradley Kudick, to approve the Waiver of 24-Month Post-Graduate Training application of Vijay Eyunni, once all requirements are met. Motion carried unanimously.

Elsadig Yousif

MOTION: Alaa Abd-Elsayed moved, seconded by Lee Ann Lau, to delegate authority to the Chairperson to act on the request of Elsadig Yousif for a Waiver of 24-Month Post-Graduate Training, subject to receipt of additional information and once all requirements are met. Motion carried unanimously.

Jordi Puente Espel

MOTION: Sheldon Wasserman moved, seconded by Lee Ann Lau, to approve the Waiver of 24-Month Post-Graduate Training application of Jordi Puente Espel, once all requirements are met. Motion carried unanimously.

Ashwin Pimpalwar

MOTION: Lee Ann Lau moved, seconded by Clarence Chou, to table the application for a Waiver of 24-Month Post-Graduate Training and Limited Privileges of Ashwin Pimpalwar, and direct staff to obtain additional information regarding the application. Motion carried unanimously.

DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS

Stipulations, Final Decisions and Orders

17 MED 474 – Richard H. Matthews, M.D.

MOTION: Bradley Kudick moved, seconded by David Bryce, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Richard H. Matthews, M.D., DLSC Case Number 17 MED 474. Motion carried unanimously.

18 MED 326 – Samuel C. Craft, M.D.

MOTION: Bradley Kudick moved, seconded by Lee Ann Lau, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Samuel C. Craft, M.D., DLSC Case Number 18 MED 326. Motion carried unanimously.

19 MED 021 – Courtney Forte, M.D.

MOTION: Alaa Abd-Elsayed moved, seconded by Sheldon Wasserman, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Courtney Forte, M.D., DLSC Case Number 19 MED 021. Motion carried unanimously.

19 MED 030 – David L. Rainiero, M.D.

MOTION: Sheldon Wasserman moved, seconded by Bradley Kudick, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against David L. Rainiero, M.D., DLSC Case Number 19 MED 030. Motion carried unanimously.

20 MED 057 – Ricardo Franco Sadud, M.D.

MOTION: Bradley Kudick moved, seconded by Michael Parish, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Ricardo Franco Sadud, M.D., DLSC Case Number 20 MED 057. Motion carried unanimously.

Complaints

17 MED 338, 18 MED 053, 19 MED 016, 19 MED 142, 19 MED 212, 19 MED 533, 19 MED 552 – M.J.T.

MOTION: Lee Ann Lau moved, seconded by David Roelke, to find probable cause in DLSC Case Numbers 17 MED 338, 18 MED 053, 19 MED 016, 19 MED 142, 19 MED 212, 19 MED 533, 19 MED 552, to believe that M.J.T. has committed unprofessional conduct, and therefore, to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat§ 448.02(3)(b). Motion carried unanimously.

(Padmaja Doniparthi recused herself and left the room for deliberation and voting in the matter concerning M.J.T., DLSC Case Numbers 17 MED 338, 18 MED 053, 19 MED 016, 19 MED 142, 19 MED 212, 19 MED 533, and 19 MED 552.)

Administrative Warnings

17 MED 105 – W.E.I.

MOTION: Bradley Kudick moved, seconded by Lee Ann Lau, to issue an Administrative Warning in the matter of W.E.I., DLSC Case Number 17 MED 105. Motion carried unanimously.

18 MED 588 – R.F.K.

MOTION: David Roelke moved, seconded by David Bryce, to issue an Administrative Warning in the matter of R.F.K., DLSC Case Number 18 MED 588. Motion carried unanimously.

19 MED 257 – B.R.B.

MOTION: Lee Ann Lau moved, seconded by Bradley Kudick, to issue an Administrative Warning in the matter of B.R.B., DLSC Case Number 19 MED 257. Motion carried unanimously.

19 MED 364 – E.E.C.

MOTION: Lee Ann Lau moved, seconded by Alaa Abd-Elsayed, to issue an Administrative Warning in the matter of E.E.C., DLSC Case Number 19 MED 364. Motion carried unanimously.

19 MED 436 – N.L.P.

MOTION: Clarence Chou moved, seconded by Milton Bond, Jr., to issue an Administrative Warning in the matter of N.L.P., DLSC Case Number 19 MED 436. Motion carried unanimously.

19 MED 541 – B.B.

MOTION: Padmaja Doniparthi moved, seconded by Bradley Kudick, to issue an Administrative Warning in the matter of B.B., DLSC Case Number 19 MED 541. Motion carried unanimously.

19 MED 586 – K.A.W.

MOTION: Milton Bond, Jr. moved, seconded by Lee Ann Lau, to issue an Administrative Warning in the matter of K.A.W., DLSC Case Number 19 MED 586. Motion carried unanimously.

Case Closings

MOTION: Lee Ann Lau moved, seconded by Alaa Abd-Elsayed, to close the following DLSC Cases for the reasons outlined below:

1. 18 MED 036 – Unknown – No Violation
2. 18 MED 497 – A.N. – Insufficient Evidence
3. 18 MED 519 – A.M.K., A.N.P. – No Violation
4. 18 MED 522 – S.M. – No Violation
5. 18 MED 560 – G.S., J.S. – No Violation
6. 18 MED 588 – A.C. – No Violation
7. 18 MED 609 – J.B.V. – Prosecutorial Discretion (P2)
8. 18 MED 618 – T.P. – No Violation, C.C. – Prosecutorial Discretion (P1)
9. 18 MED 649 – J.S. – Prosecutorial Discretion (P5)
10. 18 MED 656 – K.C. – Insufficient Evidence
11. 19 MED 047 – T.P. – No Violation
12. 19 MED 048 – M.S. – No Violation
13. 19 MED 085 – K.F. – No Violation
14. 19 MED 251 – C.B. – No Violation
15. 19 MED 320 – G.L.L. – Prosecutorial Discretion (P2)
16. 19 MED 461 – J.R.S. – No Violation
17. 19 MED 495 – K.P. – Prosecutorial Discretion (P1)
18. 19 MED 511 – B.J.H. – No Violation
19. 19 MED 539 – L.M.T. – Prosecutorial Discretion (P5)

Motion carried unanimously.

17 MED 510 – L.B.

MOTION: Lee Ann Lau moved, seconded by David Bryce, to close DLSC Case Number 17 MED 510, against L.B., for Insufficient Evidence. Motion carried unanimously.

18 MED 022 – P.T.

MOTION: Michael Parish moved, seconded by Milton Bond, Jr., to close DLSC Case Number 18 MED 022, against P.T., for No Violation. Motion carried unanimously.

18 MED 041 – J.K., M.L., D.E., J.T.

MOTION: Alaa Abd-Elsayed moved, seconded by Milton Bond, Jr., to close DLSC Case Number 18 MED 041, against J.K., M.L., D.E., & J.T., for Prosecutorial Discretion (P2). Motion carried. Opposed: Kudick

18 MED 239 – A.C.M.

MOTION: Michael Parish moved, seconded by David Roelke, to close DLSC Case Number 18 MED 239, against A.C.M., for No Violation. Motion carried unanimously.

18 MED 557 – B.T.

MOTION: Milton Bond, Jr. moved, seconded by Clarence Chou, to close DLSC Case Number 18 MED 557, against B.T., for Prosecutorial Discretion (P5). Motion carried unanimously.

Monitoring Matters

Thomas Barragry, M.D. – Requesting Termination of Order and Enrollment into PAP

MOTION: Lee Ann Lau moved, seconded by Milton Bond, Jr., to deny the request of Thomas Barragry, M.D. for Termination of Order and Enrollment into PAP. **Reason for Denial:** Lack of full compliance with the order. Motion carried unanimously.

Malissa Macias, M.D. – Requesting Reinstatement of Full Licensure

MOTION: Lee Ann Lau moved, seconded by Padmaja Doniparthi, to grant the request of Malissa Macias, M.D. for Reinstatement of Full Licensure. Motion carried unanimously.

RECONVENE TO OPEN SESSION

MOTION: David Bryce moved, seconded by David Roelke, to reconvene to Open Session. Motion carried unanimously.

The Board reconvened to Open Session at 11:50 a.m.

VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION

MOTION: Sheldon Wasserman moved, seconded by Bradley Kudick, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

(Be advised that any recusals or abstentions reflected in the closed session motions stand for the purposes of the affirmation vote.)

DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES

MOTION: David Roelke moved, seconded by Lee Ann Lau, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

MOTION: David Roelke moved, seconded by Bradley Kudick, to recognize and thank Lee Ann Lau for her years of outstanding service to the Medical Examining Board and the State of Wisconsin. Motion carried unanimously. Abstained: Lau

ADJOURNMENT

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

The meeting adjourned at 12:00 p.m.

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

Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dps@wisconsin.gov
Website: <http://dps.wi.gov>

ATHLETIC TRAINERS AFFILIATED CREDENTIALING BOARD

APPLICATION FOR A LICENSE TO PRACTICE AS AN ATHLETIC TRAINER

The Department must deny your application if you are liable for delinquent state taxes, UI contributions or child support (Wis. Stat. §§ 440.12 and 44013).

PLEASE TYPE OR PRINT IN INK <input type="checkbox"/> Your name, address, telephone number and email address are available to the public. Check box to withhold address, telephone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).			
Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>
Address (street, city, state, zip) <input type="text"/>		Daytime Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/>	
Mailing Address (if different) <input type="text"/>		Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>	
Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.		
Ethnicity/gender status information is optional.			
Ethnicity: <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hispanic <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other			
Sex: <input type="checkbox"/> M <input type="checkbox"/> F			
Email Address: <input type="text"/>			
Have you ever been licensed in Wisconsin as an Athletic Trainer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list your credential number: <input type="text"/>			
School Name: <input type="text"/>			
School Address: <input type="text"/>			
Date Diploma Granted: <input type="text"/> / <input type="text"/> / <input type="text"/> Degree: (choose one) <input type="checkbox"/> BS <input type="checkbox"/> MS <input type="checkbox"/> Dr <input type="checkbox"/> Other <input type="text"/>			

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

Exam Applicants (BOC applicants)
\$ 75.00 Initial Credential Fee

Reciprocal Applicants (licensed in another state)
\$ 75.00 Initial Credential Fee

Re-Registration Applicants (license expired more than 5 years)
\$ 75.00 Renewal Fee
\$ 25.00 Late Renewal Fee
\$ **100.00 Total Fee Attached**

For Receiving Use Only (39)

Wisconsin Department of Safety and Professional Services

THE FOLLOWING DOCUMENTS ARE REQUIRED FOR YOUR APPLICATION TO BE CONSIDERED COMPLETE:

- Completed Application (Form #2496) and appropriate fee.
- Official undergraduate transcripts submitted directly to DSPS by the degree granting institution. Transcripts must state the degree awarded, major and date degree granted. Pre-dated transcripts or transcripts supplied by the applicant are not acceptable (**not applicable to Re-Registration applicants**).
- Verification of Certification Form # 2497 directly from the Board of Certification Inc. (BOC) (**not applicable to Re-Registration applicants**).
- Submit a current copy of Certificate of Malpractice Liability Insurance (**must include amounts of coverage and expiration date**).
- Submit a current copy of CPR/AED Certificate (**front and back**).
- Verification of licensure or certification from another state submitted directly from that State Board.
- Submit proof of 30 hours of continuing education approved by the National Athletic Trainers Association Certification, Inc. (NATABOC). Hours must be obtained during the previous biennium 7/1 – 6/30 in even-numbered years (**Re-Registration applicants only**).

ARE YOU A VETERAN? If yes, please view the Department website <https://dspd.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 <http://dspd.wi.gov> and select "Professions," then "Athletic Trainer."

PRACTICE: Account for all professional and non-professional activities and practice from date of graduation to the present time.

Employer Name	Job Title and Duties <small>(i.e. office staff, food service, PA, etc.)</small>	Location of Employer	Dates Employed <small>(Month/Year)</small>
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 80%; height: 20px;" type="text"/> (State) <input style="width: 20%; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 80%; height: 20px;" type="text"/> (State) <input style="width: 20%; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 80%; height: 20px;" type="text"/> (State) <input style="width: 20%; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 80%; height: 20px;" type="text"/> (State) <input style="width: 20%; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 80%; height: 20px;" type="text"/> (State) <input style="width: 20%; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>

Pursuant to Wisconsin Statute § 448.951: **Use of Title.** Except as provided in s. 448.952, no person may designate himself or herself as an Athletic Trainer or use or assume the title "Athletic Trainer", "Licensed Athletic Trainer", "Certified Athletic Trainer" or "Registered Athletic Trainer" or append to the person's name any other title, letters or designation that represents or may tend to represent the person as an Athletic Trainer unless the person is licensed under this subchapter.

Wisconsin of Safety and Professional Services

Pursuant to Wisconsin Statute § 448.952: **Applicability.** This subchapter does not require a license under this subchapter for any of the following:

- (1) Any person lawfully practicing within the scope of a license, permit, registration or certification granted by this state or the federal government, if the person does not represent himself or herself as an Athletic Trainer.
- (2) An Athletic Training Student practicing athletic training within the scope of the student's education or training if she or she clearly indicates that he or she is an Athletic Training Student.
- (3) An Athletic Trainer who is in this state temporarily with an individual or group that is participating in a specific athletic event or series of athletic events and who is licensed, certified, or registered by another state or country or certified as an Athletic Trainer by the NATABOC or its successor agency.

I AM, OR HAVE BEEN, LICENSED IN THE FOLLOWING STATE(S):

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YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALLED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN ATHLETIC TRAINERS AFFILIATED CREDENTIALING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, CREDENTIAL NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS.

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

1.	Are you familiar with the state health laws, rules, and regulations of the Wisconsin Department of Health regarding communicable diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license, or other credential, in Wisconsin, or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Are you incarcerated, on probation, or on parole for any conviction? If yes, submit Convictions and Pending Charges Form #2252.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit Malpractice Suits or Claims Form #2829.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have your privileges ever been limited or removed? If yes, give details on an attached sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s). <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under. <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

"Ability to practice as an Athletic Trainer" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned Athletic Trainer judgments and to learn and keep abreast of athletic training developments; and
2. The ability to communicate those judgments and athletic training 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 athletic training tasks such as examination and treatment procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental, or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, Cerebral Palsy, epilepsy, Muscular Dystrophy, Multiple Sclerosis, cancer, heart disease, Diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding, the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of Controlled Dangerous Substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner.

Wisconsin Department of Safety and Professional Services

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

11.	Do you have a medical condition which in any way impairs or limits your ability to practice as an Athletic Trainer with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice as an Athletic Trainer with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications), or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Have you ever been diagnosed as having, or have you ever been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No

CERTIFICATION OF LEGAL STATUS:

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

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

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

CONTINUING DUTY OF DISCLOSURE

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

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 of Applicant

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

DIETITIANS AFFILIATED CREDENTIALING BOARD

INSTRUCTIONS FOR CERTIFICATION TO PRACTICE AS A DIETITIAN

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

1. Application (**Form #2113**) and appropriate fee
2. Certificate of Professional Education (**Form# 2111**), not applicable to Re-Registration applicants
3. Dietetics Practicum Experience (**Form #2128**)
4. Proof of passage of the Academy of Nutrition and Dietetics (**AND**) examination, or Verification of Registration (**Form #2115**)
5. Letters from all State Boards where licensed, active and inactive
6. Request for a Temporary Dietitian Certificate (**Form# 2112**), if applicable
7. Convictions and Pending Charges (**Form #2252**), if applicable
8. Malpractice Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, if applicable.
9. Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc.

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DIETITIANS AFFILIATED CREDENTIALING BOARD

APPLICATION FOR CERTIFICATION TO PRACTICE AS A DIETITIAN

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK

Your name, address, telephone number and email address are available to the public. Check box to withhold address, telephone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>
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Address (street, city, state, zip) <input type="text"/>	Daytime Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/>
---	---

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

Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.
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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

Email Address

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

School Name <input type="text"/>	Degree: (choose one) <input type="checkbox"/> BS <input type="checkbox"/> MS <input type="checkbox"/> Dr. <input type="checkbox"/> Other <input type="text"/>
School Address (city, state) <input type="text"/> <input type="text"/>	
Date Diploma Granted <input type="text"/> / <input type="text"/> / <input type="text"/>	Specialty: <input type="text"/>

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

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

Exam Applicants
\$ 75.00 Total Exam Fee Attached

Reciprocal Applicants (for applicants who hold a credential in another state.)
\$ 75.00 Total Reciprocal Fee Attached

Re-Registration Applicants (For applicants with a credential expired for over (5) five years.)
\$ 75.00 Renewal Fee
\$ 25.00 Late Fee
\$100.00 Total Fee Attached

For Receiving Use Only (29)

Wisconsin Department of Safety and Professional Services

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

5.	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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Are you incarcerated, on probation, or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have your privileges ever been limited or removed? If yes, give details on an attached sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

"Ability to practice as a Dietitian" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned dietetic judgments and to learn and keep abreast of dietetic developments; and
2. The ability to communicate those judgments and dietetic 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 dietetic tasks such as examination and treatment 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.**

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11.	Do you have a medical condition, which in any way impairs or limits your ability to practice as a Dietitian with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice as a Dietitian with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Wisconsin Department of Safety and Professional Services

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>.

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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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Madison, WI 53705
E-Mail: dsps@wisconsin.gov
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MASSAGE THERAPY AND BODYWORK THERAPY CREDENTIALING BOARD **INFORMATION FOR MASSAGE THERAPIST OR BODYWORK THERAPIST**

LICENSURE ELIGIBILITY REQUIREMENTS BASED ON METHOD OF APPLICATION:

Licensure by Examination or Re-Registration: An applicant is eligible for licensure as a Massage Therapist or Bodywork Therapist if the applicant:

1. Completes and submits Application (**Form #2960**) and pays the fee specified in Wis. Stat. § 440.05(1).
2. Submits a copy of current CPR/AED certificate from a DHS approved provider. For a listing of approved providers go to http://www.dhs.wisconsin.gov/ems/License_certification/CPR.htm.
3. Is 18 years of age or older.
4. Has graduated from high school or attained high school graduation equivalency as determined by the Department of Public Instruction under Wis. Stat. § 115.29(4). Complete Massage Therapy and Bodywork Therapy Program Curriculum (**Form #2962**). This form must be completed by your school and returned directly to the Department. If your school is not Educational Approval Program (EAP) approved, you must also submit an official transcript.
5. **Passes the Wisconsin State Law Examination:** The Wisconsin Massage Therapy and Bodywork Therapy State Law Exam is an on-line open book examination on the Wisconsin Statutes and Administrative Codes that govern Massage Therapists and Bodywork Therapists. Candidates will be assigned an ID#, test name, and password after submitting an application.

Important: (for Graduates from WI State Schools on Or After 1/1/12) You are required to take and pass this exam as a prerequisite to graduation. Your Massage Therapy or Bodywork Therapy school should notify students when and where to complete the exam; it is recommended that the applicant complete the exam as soon as reasonable. Upon completion of the exam, the applicant will be presented with the option to "Print test feedback report." **The applicant must choose this option** ("Print test feedback report") to have the exam score available for review by the school (**do not submit to DSPS**). **DSPS does not have the ability to recall a score**. If the applicant fails to print the test feedback report when given the option, the applicant will be required to retake the exam and pay an additional fee.

6. Has in effect malpractice liability insurance coverage in an amount that is not less than \$1,000,000 per occurrence and \$1,000,000 for all occurrences in one year. **Malpractice Liability Insurance:** All applicants are required to submit a copy of a current certificate of malpractice liability insurance, which shows the amounts of coverage and expiration date.
7. Has not been convicted of an offense under Wis. Stat. § 940.22, 940.225, 944.15, 944.17, 944.30, 944.31, 944.32, 944.33, 944.34, 948.02, 948.025, 948.08, 948.085, 948.09, 948.095, 948.10, or a comparable offense under federal law or a law of any other state.
8. Subject to Wis. Stat. § 111.321, 111.322 and 111.335, Stats, has not been convicted of any other offense not listed in item (7) above, the circumstances of which substantially relate to the practice of Massage Therapy or Bodywork Therapy.
9. Has passed one of the following nationally administrated examinations: (exam applicants only)
 - National Certification Examination for Therapeutic Massage
 - National Certification Examination for Therapeutic Massage and Bodywork
 - Asian Bodywork Therapy Examination of the National Certification Commission for Acupuncture and Oriental Medicine
 - Massage and Bodywork Licensing Examination

National Score Report: NCBTMB, NCCAOM, or FSMBT

Applicants who passed either of the National Certification Examinations of the National Certification Board for Therapeutic Massage and Bodywork (NCBTMB). Complete NCBTMB Official Score Report Request Form. Attach appropriate fee and forward to address indicated on form. Forms are available at <http://www.ncbtmb.org>. Your scores must be returned **directly** to the Department from NCBTMB. Scores received from the applicant will not be accepted.

Applicants who have passed the Asian Bodywork Therapy Exam of the National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM)

Complete NCCAOM Request Form. Attach appropriate fee and forward to address indicated on form.

Forms are available at <http://www.nccaom.org>. Your scores must be returned directly to the Department from NCCAOM. Scores received from the applicant will not be accepted.

Wisconsin Department of Safety and Professional Services

Applicants who have passed the Federation of State Massage Therapy Board's (FSMTB) Massage and Bodywork Licensing Examination (MBLEx)

Complete Massage and Bodywork Licensing Examination Mobility Form. Attach appropriate fee and forward to address indicated on form. Forms are available at <http://www.fsmtb.org>. Your scores must be returned directly to the Department from FSMTB. Scores received from the applicant will not be accepted.

Temporary Licensure

This provision applies only to those eligible for licensure by examination and who meet all other requirements for licensure, but who have not yet received scores from an approved nationally administered entry-level competency assessment examination.

A temporary license expires 6 months after the date of issuance or when the Department receives notice that the temporary licensee has failed or passed the examination required by Wis. Stat. § 460.06, whichever is first.

- a. A temporary license may not be renewed; and
- b. No person shall be issued more than one temporary license.

Practice under a temporary license shall be under the supervision of a licensed Massage Therapist or Bodywork Therapist, at the level of general, direct, or direct one-on-one supervision as necessary to avoid unacceptable risk of harm to the client. The supervising Massage Therapist or Bodywork Therapist is responsible for determining the level of supervision necessary to avoid unacceptable risk of harm to the client and is responsible for the acts of the temporary licensee.

The supervisor may be subject to discipline for failure to appropriately supervise the temporary licensee and/or for failure to ensure that, the temporary licensee adheres to the Board's rules and the standards of minimal competence.

The supervisor responsible for the temporary licensee shall ensure that clients know the temporary licensee is not fully licensed and that the supervisor is ultimately responsible for the care provided. It is recommended that this information be documented in the client record.

Licensure by Reciprocity: An applicant is eligible for reciprocal licensure as a Massage Therapist or Bodywork Therapist if the applicant:

1. Completes and submits Application (**Form #2960**) and pays the fee specified in Wis. Stat. § 440.05(1).
2. Holds a current similar license, registration or certificate to practice Massage Therapy or Bodywork Therapy in another U.S. state or territory or another country, the requirements for which are substantially equivalent to the requirements under Wis. Stat. § 460.05. "Substantially Equivalent" means the requirements must include either of the following:
Certification by the NCBTMB or any other organization accredited by the National Commission for Certifying Agencies to certify Massage Therapy or Bodywork Therapy;
or
Completion of at least 600 classroom hours of instruction in Massage Therapy or Bodywork Therapy at a school approved by an accrediting agency.
3. Submits verification of a current license, registration or certification issued by another U.S. state or territory or province of another country. You are required to have each jurisdiction in which you have ever been credentialed submit letters of verification to DSPS. The letters must indicate your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions. City or county certification/licensure does not meet the State licensure requirement, nor will you need to submit verification from these jurisdictions.
4. **Passes the Wisconsin State Law Examination:** The Wisconsin Massage Therapy and Bodywork Therapy State Law Exam is an on-line open book examination on the Wisconsin Statutes and Administrative Codes that govern Massage Therapists and Bodywork Therapists. Candidates will be assigned an ID#, test name, and password after applying.
5. Has not been convicted of an offense under Wis. Stats. § 940.22, 940.225, 944.15, 944.17, 944.30, 944.31, 944.32, 944.33, 944.34, 948.02, 948.025, 948.08, 948.085, 948.09, 948.095, 948.10, or a comparable offense under federal law or a law of any other state.
6. Subject to Wis. Stats. § 111.321, 111.322 and 111.335, has not been convicted of any other offense not listed in Item (6) above, the circumstances of which substantially relate to the practice of Massage Therapy or Bodywork Therapy.
7. Has in effect malpractice liability insurance coverage in an amount that is not less than \$1,000,000 per occurrence and \$1,000,000 for all occurrences in one year. Malpractice Liability Insurance: All applicants are required to submit a copy of a current certificate of malpractice liability insurance, which shows the amounts of coverage and expiration date.
8. Submit a copy of current CPR/AED certificate from a DHS approved provider. For a listing of approved providers go to http://www.dhs.wisconsin.gov/ems/License_certification/CPR.htm.
9. Has not engaged in conduct while practicing Massage Therapy or Bodywork Therapy that jeopardizes the health, safety, or welfare of a client or that evidences a lack of knowledge of, inability to apply, or the negligent application of, principles or skills of Massage Therapy or Bodywork Therapy.

Wisconsin Department of Safety and Professional Services

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

- Application (**Form #2960**) and appropriate fee
- Copy (front and back) of current CPR/AED card from DHS approved provider
- Passage of the Wisconsin Statutes and Rules Exam
- Massage Therapy or Bodywork Therapy Program Curriculum (**Form #2962**) (exam and re-registration applicants only) and official transcripts if required.
- Copy of Certificate of Insurance for malpractice liability policy showing applicant as policyholder and insured with coverage not less than \$1,000,000 per occurrence and \$1,000,000 for all occurrences in one year.
- Proof of passing National exam received directly from National Exam Services (exam applicants only)
- Verification of licensure or certification from another state submitted directly from that state(s) board(s).
- Convictions and Pending Charges (**Form #2252**), if applicable
- Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, if applicable

ARE YOU A VETERAN? If yes, please view the Department website at <http://dsps.wi.gov> under "License, Permits, and Registrations and select Military Benefits Related to Licensure for Eligible Veterans Services Members and Spouses" for eligibility requirements.

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

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

If you qualify, are you requesting equivalency of your Military Training and experience? Yes No

If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

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

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

You may contact the DVA at 1-800-WisVets or www.WISVETS.com 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."

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

<input type="text"/>														
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For each credential listed above, you are required to have each State Board or territory of the United States submit a letter of verification to the Wisconsin Massage Therapy or Bodywork Therapy Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

FOR TEMPORARY LICENSE ONLY: (Please check one)

I plan to take the next National Certifying Examination on / /

I have taken and passed the National Certifying Examination

Wisconsin Department of Safety and Professional Services

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

1.	Have you graduated from high school or attained high school graduation equivalency? If yes, give details below. Name of High School <input style="width: 90%; height: 20px;" type="text"/> Date of Graduation: <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> Location (city, state, country) <input style="width: 90%; height: 20px;" type="text"/> OR Granting Agency <input style="width: 90%; height: 20px;" type="text"/> Date High School Equivalency Obtained <input style="width: 90%; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health Services regarding communicable diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you <u>ever</u> failed to pass any state or national board accrediting examination in the field of Massage Therapy or Bodywork Therapy, including but not limited to the NCBTMB exams, MBLEx, NCCAOM (this does not include examinations taken solely as part of a Massage Therapy and Bodywork Therapy education program)? If yes, provide details <input style="width: 90%; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you ever surrendered, resigned, canceled, or been denied a professional license, or other credential in Wisconsin, or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Has any governmental 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have you ever been 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Are you incarcerated, on probation, or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <input style="width: 90%; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <input style="width: 90%; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Wisconsin Department of Safety and Professional Services

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

"Ability to practice Massage Therapy or Bodywork Therapy" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned Massage Therapy or Bodywork Therapy judgments and to learn and keep abreast of Massage Therapy or Bodywork Therapy developments; and
2. The ability to communicate those judgments and Massage Therapy or Bodywork Therapy 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 Massage Therapy or Bodywork Therapy tasks, 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.

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

CERTIFICATION OF LEGAL STATUS:

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

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

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

Wisconsin Department of Safety and Professional Services

CONTINUING DUTY OF DISCLOSURE

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

AFFIDAVIT OF APPLICANT

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

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

Signature: Date: / /

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 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>

OCCUPATIONAL THERAPISTS AFFILIATED CREDENTIALING BOARD

OCCUPATIONAL THERAPIST OR OCCUPATIONAL THERAPY ASSISTANT LICENSURE INFORMATION

All applicants shall pass the certification examination for Occupational Therapy or Occupational Therapy Assistant by the National Board for Certification in Occupational Therapy, as well as an online examination on Wisconsin Statutes and Administrative Code.

Applicants **may** be required to complete an oral examination if he/she:

1. Has a medical condition which in any way impairs or limits the applicant's ability to practice occupational therapy or as an occupational therapy assistant with reasonable skill and safety;
2. Uses chemical substances that impair in any way the applicant's ability to practice occupational therapy or as an occupational therapy assistant with reasonable skill and safety;
3. Has been diagnosed as suffering from pedophilia, exhibitionism, or voyeurism;
4. Has within the past two (2) years engaged in the illegal use of controlled dangerous substances;
5. Has been subject to adverse formal action during the course of occupational therapy or occupational therapy assistant education, postgraduate training, hospital practice, or other occupational therapy employment;
6. Has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction;
7. Has been convicted of a crime which substantially relates to the practice of occupational therapy or as an occupational therapy assistant;
8. Has not practiced occupational therapy or as an occupational therapy assistant for a period of five (5) years prior to application, unless the applicant has graduated from a school of occupational therapy or occupational therapy assistant school within that period. Practice for the purposes of this paragraph includes direct patient treatment and education, instruction in an occupational therapy program recognized by the board, occupational therapy research, or service in administrative positions for health care providers or governmental bodies with responsibility relating to occupational therapy;
9. Has graduated from an occupational therapy or occupational therapy assistant school not approved by the board;
10. Was a resident of Wisconsin and eligible for certification as an occupational therapist or occupational therapy assistant on August 1, 1989, but did not apply for certification until after August 1, 1991.

An applicant who meets any of the above criteria shall be reviewed by the Occupational Therapists Affiliated Credentialing Board to determine whether an applicant is required to complete an oral examination.

All examinations shall be conducted in the English language. Where both written and oral examinations are required, they shall be scored separately, and the applicant shall achieve a passing grade on both examinations to qualify for a license.

If selected to appear for an oral examination, the applicant will be advised of the date upon completion of their application. The content and process of this examination, and candidate performance statistics, are regularly evaluated by the Department and the Occupational Therapists Affiliated Credentialing Board to assure that this examination fairly and effectively assesses competencies necessary to practice as an occupational therapist or as an occupational therapy assistant.

Wisconsin Department of Safety and Professional Services

TEMPORARY LICENSE

1. An applicant for a license may apply to the board for a temporary license to practice as an Occupational Therapist or as an Occupational Therapy Assistant if the applicant:
 - a) Submits DSPTS Application (**Form #1569**), required documents under sec. OT 2.02, Wis. Admin. Code, and pays the required fee.
 - b) Is a graduate of an approved school and is scheduled to take the national certification examination for occupational therapy or an occupational therapy assistant, or has taken the national certification examination and is awaiting results.
2. Practice during the period of the temporary license shall be in consultation, at least monthly, with an occupational therapist who shall at least once each month endorse the activities of the person holding the temporary license.
3. A temporary license expires when the applicant is notified he/she failed the national certification examination or on the date the board grants or denies an applicant a permanent license, whichever is first.
4. A temporary license shall remain in effect for six (6) months and may not be renewed.

RE-REGISTRATION LICENSE

Re-registration applicants must submit 24 points (one point = one hour) of continuing education (CE) obtained in the previous biennium (6/1/odd – 5/31/odd). Refer to Chapter OT 3 Biennial Registration in the Wisconsin Administrative code for further information.

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
 Madison, WI 53708-8935
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Office Location: 4822 Madison Yards Way
 Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

OCCUPATIONAL THERAPISTS AFFILIATED CREDENTIALING BOARD

APPLICATION FOR A LICENSE TO PRACTICE OCCUPATIONAL THERAPY OR AS AN OCCUPATIONAL THERAPY ASSISTANT

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				<input type="checkbox"/> 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).
License Applying for: <input type="checkbox"/> Occupational Therapist–New License <input type="checkbox"/> Occupational Therapy Assistant–New License <input type="checkbox"/> Occupational Therapist-Re-Registration <input type="checkbox"/> Occupational Therapy Assistant-Re-Registration				
Last Name	First Name	MI	Former / Maiden Name(s)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address (street, city, state, zip)			Daytime Telephone Number	
<input type="text"/>			<input type="text"/> - <input type="text"/> - <input type="text"/>	
Mailing Address (if different)			Date of Birth	
<input type="text"/>			<input type="text"/> / <input type="text"/> / <input type="text"/>	
Social Security #	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.			
<input type="text"/> - <input type="text"/> - <input type="text"/>				
Ethnicity/gender status information is optional.				
Ethnicity:	<input type="checkbox"/> White, not of Hispanic origin	<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> Hispanic	
	<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Asian or Pacific Islander	<input type="checkbox"/> Other	
Sex:	<input type="checkbox"/> M <input type="checkbox"/> F			
Have you ever been licensed in Wisconsin as a Occupational Therapist or Occupational Therapist Assistant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list your credential number:				
<input type="text"/>				
Email Address				
<input type="text"/>				
School Name			School Address (street, city, state)	
<input type="text"/>			<input type="text"/>	
Date Degree Granted			Degree	
<input type="text"/> / <input type="text"/> / <input type="text"/>			<input type="text"/>	

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

- I am seeking a Veteran Fee Waiver** (for Initial Credential Fee only, see page 2 for further information)
 - Exam Applicants** (NBCOT)
 - OT OTA
 - \$ 75.00 Initial Credential Fee
 - \$ 75.00 State Law Exam
 - \$150.00 Total Fee Attached**
 - Request for a Temporary License**
 - \$ 10.00** (Is required in addition to the above fee and is non-refundable, for Exam applicants only.)
 - Re-Registration Applicants** (previous WI license-expired more than 5 years)
 - OT OTA
 - \$ 75.00 Renewal Credential Fee
 - \$ 25.00 Late Renewal Fee
 - \$ 75.00 State Law Exam
 - \$175.00 Total Fee Attached**
- Oral Examination Fee: \$266.00**
 If you are selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for this exam.

For Receiving Use Only (26/27)

Wisconsin Department of Safety and Professional Services

ALL OF THE FOLLOWING DOCUMENTS ARE REQUIRED TO PROCESS THIS APPLICATION:

All Applicants

- Fee(s) attached to this application
- Letters from all State Boards or other jurisdictions where licensed or credentialed (**includes active and inactive licenses**)
- Copies of malpractice suit(s)
- Wisconsin Statutes and Rules Examination
- Certificate of Professional Education (Form #1570) (**Not applicable to Re-Registration Applicants**)
- Verification of certification from National Board for Certification in Occupational Therapy (**Not applicable to Re-Registration Applicants**)

Re-Registration Applicants

- 24 points (one point = one hour) of CE obtained in previous biennium (6/1/odd – 5/31/odd).

ARE YOU A VETERAN? If yes, please view the Department website at <http://dsps.wi.gov> 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".

PRACTICE: Account for all activities and practice starting from the date of graduation to the present time. Must include professional and nonprofessional activities. All time and dates must be accounted for. (Attach additional sheets, if necessary.) **If currently employed at a location indicate 'to present' in lieu of a 'To' date.**

Employer Name	Location of Employment (city/state)	Dates Employed (month/year)	# of Hours per Week	Job Title and Duties
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>

Wisconsin Department of Safety and Professional Services

FOR TEMPORARY LICENSE (not applicable to Re-Registration Applicants): (check one)

- I plan to take the National Certifying Examination on :
- I have taken and passed the National Certifying Examination.

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

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

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

1..	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever failed to pass any state board examination, national board examination, NBCOT? If yes, provide details below: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. If yes, submit Convictions and Pending Charges (Form #2252).	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have your privileges ever been limited or removed? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have any suits or claims ever been filed against you as a result of professional services? If yes, Malpractice Suits or Claims (Form #2829).	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Wisconsin Department of Safety and Professional Services

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

"Ability to practice Occupational Therapy or as a Occupational Therapist Assistant " is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned occupational therapy judgments and to learn and keep abreast of occupational therapy developments; and
2. The ability to communicate those judgments and occupational therapy 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 the duties of an occupational therapist or occupational therapist assistant, 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.

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

Wisconsin Department of Safety and Professional Services

CERTIFICATION OF LEGAL STATUS:

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

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

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

CONTINUING DUTY OF DISCLOSURE:

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

AFFIDAVIT OF APPLICANT:

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

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

Signature: Date: / /

Wisconsin Department of Safety and Professional Services

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

Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

PODIATRY AFFILIATED CREDENTIALING BOARD

INFORMATION FOR COMPLETING LICENSE TO PRACTICE PODIATRIC MEDICINE AND SURGERY

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

1. **National Board Scores** Original score reports must be submitted directly from the testing agency. Both passing and failing scores are required. Copies sent from applicant, photocopies, online verifications, or faxes are not acceptable. Please request the testing agency mail your scores directly to DSPS, Attn: Podiatry Affiliated Credentialing Board, P.O. Box 8935, Madison, WI 53708-8935, email scores directly to DSpscMedBdAffiliates@wi.gov or fax with agency cover sheet/letter to 608-261-7083.
2. **Certificate of Professional Education (Form #1921)**
3. **Certificate of Postgraduate Training (Form #2480)**
4. **Verification of Licensure in Other State(s)** Please contact each state board you have ever held or current hold a podiatry license in and request verification of licensure be submitted directly to our Department. State Boards may email the verification directly to DSpscMedBdAffiliates@wi.gov or fax with agency cover sheet/letter to 608-261-7083.
5. **Examination on Wisconsin Law** An applicant shall successfully complete an online examination on Wisconsin Statutes and Rules relating to the practice of podiatry before a license can be issued in Wisconsin. Information for the online examination will be provided after an application for licensure has been received at DSPS.

Applicants **may** be required to complete an oral examination per Wis. Admin. Code § POD 1.06(1). If selected to appear for an oral examination, the applicant will be advised of the date upon completion of their application.

MALPRACTICE LIABILITY INSURANCE COVERAGE FOR PODIATRISTS:

Per Wis. Stat. § 448.655 a licensed podiatrist shall annually submit to the board evidence that the podiatrist has in effect malpractice liability insurance coverage in the amount of at least \$1,000,000 per occurrence and \$1,000,000 for all occurrences in one year or file an exemption under conditions stated below.

A copy of certificate of insurance showing limits of liability coverage and dates of coverage must be submitted to the Podiatry Affiliated Credentialing Board at the address listed above.

After you have been issued a WI Podiatry License, please send a copy of your Certificate of Insurance to our Department or if you qualify for an exemption, complete ([Form #2700](#)) and submit to our Department.

The Board may suspend, revoke or refuse to issue or renew the license of a podiatrist who fails to procure or to submit proof of the malpractice liability insurance coverage required under Wis. Stat. § 448.655(3).

Wisconsin Department of Safety and Professional Services

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

- | | |
|--|---|
| <input type="checkbox"/> Application (Form #575) and appropriate fee
<input type="checkbox"/> Certificate of Professional Education (Form #1921)
<input type="checkbox"/> Certificate of Postgraduate Training (Form #2480)
<input type="checkbox"/> National Examination Scores (sent directly from the National Board)
<input type="checkbox"/> Letters from all State Boards where licensed, active and inactive | <input type="checkbox"/> Convictions and Pending Charges (Form #2252), if applicable
<input type="checkbox"/> Malpractice Suits or Claims (Form #2829) and copies of malpractice suit, court documents with allegations and settlement, if applicable
<input type="checkbox"/> Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc. |
|--|---|

ARE YOU A VETERAN? If yes, please view the Department website at <http://dsps.wi.gov> under "License, Permits, and Registrations" and select "Military Benefits Related to Licensure for Eligible Veterans Services Members and Spouses" for eligibility requirements.

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

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

If you qualify, are you requesting equivalency of your Military Training and experience? Yes No

If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

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

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

You may contact the DVA at 1-800-WisVets or www.WISVETS.com 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.

Post-Graduate Training Facility	Location of Facility (City/State)	Dates of Training (Month/Year)
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 90%; border: none;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 90%; border: none;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 90%; border: none;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>

Wisconsin Department of Safety and Professional Services

EXPERIENCE AND PRACTICE: Outline in chronological order all activities from the date of graduation from podiatric school to the present time. Must include professional and nonprofessional activities. All time and dates must be accounted for.

Employer Name	Location of Employment (City/State)	Dates of Employment (Month/Year)	The Position in which you are/were Employed
	(City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	
	(City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	
	(City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	
	(City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	

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 Podiatry Affiliated Credentialing 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.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever failed to pass any state board examination, national board examination? If yes, provide details below: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. If yes, submit Convictions and Pending Charges (Form #2252).	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Are you incarcerated, on probation, or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have any suits or claims ever been filed against you as a result of professional services? If yes, Malpractice Suits or Claims (Form #2829).	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned podiatry judgments and to learn and keep abreast of podiatry developments; and
2. The ability to communicate those judgments and podiatric 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.**

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Wisconsin Department of Safety and Professional Services

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

CERTIFICATION OF LEGAL STATUS:

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

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

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

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AFFIDAVIT OF APPLICANT:

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

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

Signature: Date: / /

Wisconsin Department of Safety and Professional Services

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

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

MEDICAL EXAMINING BOARD

APPLICATION FOR LICENSURE AS AN ANESTHESIOLOGIST ASSISTANT

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				<input type="checkbox"/> 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 <input type="text"/>		First Name <input type="text"/>		MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>		
Address (street, city, state, zip) <input type="text"/>					Daytime Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/>		
Mailing Address (if different) <input type="text"/>					Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>		
Social Security # <input type="text"/> - <input type="text"/> - <input type="text"/>				Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.			
Ethnicity/gender status information is optional.							
Ethnicity:		<input type="checkbox"/> White, not of Hispanic origin		<input type="checkbox"/> American Indian or Alaskan		<input type="checkbox"/> Hispanic	
		<input type="checkbox"/> Black, not of Hispanic origin		<input type="checkbox"/> Asian or Pacific Islander		<input type="checkbox"/> Other	
Sex:		<input type="checkbox"/> M <input type="checkbox"/> F					
Email Address <input type="text"/>							
Have you ever been licensed in Wisconsin as an Anesthesiologist Assistant?					<input type="checkbox"/> Yes <input type="checkbox"/> No if yes, list your credential number		
<input type="text"/>					<input type="text"/>		
School Name <input type="text"/>				School Address (city, state) <input type="text"/>			
Date Diploma Granted <input type="text"/> / <input type="text"/> / <input type="text"/>				Degree <input type="text"/>		Specialty <input type="text"/>	

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

- I am seeking a Veteran Fee Waiver** (for Initial Credential Fee only, see page 2. for further information)
- \$ 75.00 **Initial Licensure Fee**
- \$ 10.00 **Request for a Temporary License** (is required in addition to the above fee, non-refundable)

For Receiving Use Only (17)

Wisconsin Department of Safety and Professional Services

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

- Application (**Form #2976**) and appropriate fee
- National Examination Scores (**Form #2975**)
- Certificate of Professional Education (**Form #2977**)
- Letters from all State Boards where licensed, active and inactive
- 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.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."

PRACTICE: Account for all activities and practice starting from the date of graduation to the present time. Must include professional and nonprofessional activities. All time and dates must be accounted for. (Attach additional sheets, if necessary.)

Employer	Location Of Employment (City/State)	Dates Employed (Month/Year)
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 90%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 90%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 90%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>

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 as an Anesthesiologist Assistant" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned Anesthesiologist Assistant judgments and to learn and keep abreast of Anesthesiologist Assistant developments; and
2. The ability to communicate those judgments and Anesthesiologist Assistant 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.

11.	Do you have a medical condition, which in any way impairs or limits your ability to practice Anesthesiologist Assistant with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice Anesthesiologist Assistant with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No

CERTIFICATION OF LEGAL STATUS:

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

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

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

Wisconsin Department of Safety and Professional Services

CONTINUING DUTY OF DISCLOSURE

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

AFFIDAVIT OF APPLICANT

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

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

Signature: Date: / /

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 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>

MEDICAL EXAMINING BOARD

PERFUSIONIST LICENSURE INFORMATION

All applicants are required to pass the American Board of Cardiovascular Perfusion examination as well as an open book examination on Wisconsin Statutes and Administrative Code. Applicants may be required to complete an oral examination if he/she:

1. has a medical condition which in any way impairs or limits the applicant's ability to practice as a Perfusionist with reasonable skill and safety;
2. uses chemical substances so as to impair in any way the applicant's ability to practice as a Perfusionist with reasonable skill and safety;
3. have been diagnosed as suffering from pedophilia, exhibitionism or voyeurism;
4. has within the past 2 years engaged in the illegal use of controlled dangerous substances;
5. has been subject to adverse formal action during the course of perfusion education, postgraduate training, hospital practice, or other perfusion employment;
6. has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction;
7. has been convicted of a crime the circumstances of which substantially relate to the practice of perfusion;
8. has not practiced perfusion for more than 1,200 hours during the last 3 years;
9. has practiced over 1,200 hours in the last 3 years but practice was limited;
10. has been found negligent in the practice of perfusion or has been a party in a lawsuit in which it was alleged that the applicant has been negligent in the practice of perfusion.

An applicant, who meets any of the above criteria, will be reviewed by Perfusionist Examining Council members. The Council shall determine whether the applicant is eligible for a regular license without completing an oral examination. If you should be selected for an oral examination, there will be an additional fee of \$266.00.

All examinations shall be conducted in the English language. Where both written and oral examinations are required, they shall be scored separately and the applicant is required to achieve a passing grade on both examinations to qualify for a license.

If you are selected to appear for an oral examination, you will be advised of the date upon completion of your application.

Locum Tenens Licensure

Applicants for Locum Tenens licensure will need to submit the following:

- Application with supporting documents
- Wisconsin Statutes and Rules Exam
- Photocopy of your current American Board of Cardiovascular Perfusion certification
- Letter requesting your services from a licensed Perfusionist in Wisconsin including the dates of employment

Temporary Licensure

Applicants for temporary licensure will need to submit the following:

- Wisconsin Statutes and Rules Exam
- Fees for both Permanent and Temporary
- Application with supporting documents

Wisconsin Department of Safety and Professional Services

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

MEDICAL EXAMINING BOARD

APPLICATION FOR LICENSURE TO PRACTICE AS A PERFUSIONIST

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 <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>
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Address (street, city, state, zip) <input type="text"/>	Daytime Telephone Number <input type="text"/>
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Mailing Address (if different) <input type="text"/>	Date of Birth <input type="text"/>
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Social Security # <input type="text"/>	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.
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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

Email Address:

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

School Name

School Address (city, state)

Date Degree Conferred

Degree

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)
- ABCP and State Law**
 \$ 75.00 Initial Credential Fee
 \$ 75.00 State Law Exam
 \$ 150.00 **Total Fee Attached**
- Request for a Temporary License**
 \$ 10.00 Is required in addition to the above fee (non-refundable)
- Locum Tenens**
 \$ 10.00 Temporary Initial Credential Fee
 \$ 75.00 State Law Exam
 \$ 85.00 **Total Fee Attached**

For Receiving Use Only (18)

Wisconsin Department of Safety and Professional Services

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

- Application (**Form #2562**) and appropriate fee
- Certificate of Professional Education (**Form #2564**)
- Letters from all State Boards where licensed, active and inactive
- Verification of Certification from the American Board of Cardiovascular Perfusion (**Form # 2567**)
- Employment Verification (**Form #2565**)
- 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

ARE YOU A VETERAN? If yes, please view the Department website at <http://dsps.wi.gov> under "License, Permits, and Registrations and select Military Benefits Related to Licensure for Eligible Veterans Services Members and Spouses" for eligibility requirements.

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

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

If you qualify, are you requesting equivalency of your Military Training and experience? Yes No

If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

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

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

You may contact the DVA at 1-800-WisVets or www.WISVETS.com 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."

PRACTICE: Account for all professional and nonprofessional activities and practice starting from the date of graduation to the present time. (Attach additional sheets, if necessary.)

Name and Location of Facility	Dates Employed (Month/Year)	Hours	Job Title and Duties
(Name) <input style="width: 100%;" type="text"/> (City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (Country) <input style="width: 100%;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Hours/Week <input style="width: 50px;" type="text"/>	(Job Title) <input style="width: 100%;" type="text"/> (Job Duties) <input style="width: 100%; height: 40px;" type="text"/>
(Name) <input style="width: 100%;" type="text"/> (City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (Country) <input style="width: 100%;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Hours/Week <input style="width: 50px;" type="text"/>	(Job Title) <input style="width: 100%;" type="text"/> (Job Duties) <input style="width: 100%; height: 40px;" type="text"/>
(Name) <input style="width: 100%;" type="text"/> (City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (Country) <input style="width: 100%;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Hours/Week <input style="width: 50px;" type="text"/>	(Job Title) <input style="width: 100%;" type="text"/> (Job Duties) <input style="width: 100%; height: 40px;" type="text"/>

Wisconsin Department of Safety and Professional Services

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

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

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

1.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever failed to pass any state board examination, national board examination, or ABCP examination? If yes, provide details on attached sheet	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you ever been convicted of a misdemeanor or a felony, or do you have any felony or misdemeanor charges pending against you? If yes, submit Convictions and Pending Charges (Form #2252).	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have any suits or claims ever been filed against you as a result of professional services? If yes, 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have your privileges ever been limited or removed? If yes, give details on an attached sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

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

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, Cerebral Palsy, epilepsy, Muscular Dystrophy, Multiple Sclerosis, cancer, heart disease, Diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of Controlled Dangerous Substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner.

Wisconsin Department of Safety and Professional Services

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

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

CERTIFICATION OF LEGAL STATUS:

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

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

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

CONTINUING DUTY OF DISCLOSURE

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

AFFIDAVIT OF APPLICANT

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

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

Signature: Date: / /

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MEDICAL EXAMINING BOARD

PHYSICIAN ASSISTANT CREDENTIALING INFORMATION

An applicant **may** be required to complete an oral examination if he/she:

1. has a medical condition which in any way impairs or limits the applicant's ability to practice as a Physician Assistant with reasonable skill and safety;
2. uses chemical substances so as to impair in any way the applicant's ability to practice as a Physician Assistant with reasonable skill and safety;
3. has been diagnosed with conditions that may create a risk of harm to a patient or the public;
4. has within the past two (2) years engaged in the illegal use of controlled dangerous substances;
5. has been subject to adverse formal action during the course of Physician Assistant education, postgraduate training, hospital practice, or other Physician Assistant employment;
6. has been disciplined or had certification denied by a licensing or regulatory authority in Wisconsin or another jurisdiction;
7. has been convicted of a crime, the circumstances of which substantially relate to the practice of physician assistants;
8. has not practiced as a Physician Assistant for a period of three (3) years prior to application, unless the applicant has been graduated from an approved educational program for Physician Assistant within that period.
9. has been found to have been negligent in the practice as a Physician Assistant or has been a party in a lawsuit in which it was alleged that the applicant has been negligent in the practice of Medicine.

If you are selected to appear for an oral examination, an additional examination fee of \$266.00 will be required prior to being scheduled.

ALL CANDIDATES are required to take an online examination on Wisconsin Statutes and Rules relating to Physician Assistant practice in this state. Instructions will be given upon initial review of the application. If you fail this examination, an additional fee of \$75.00 will be required for you to retake it.

TEMPORARY LICENSE (only applicable to new graduates waiting to sit for the PANCE exam)

An applicant for licensure may apply to the Board for a temporary license to practice as a Physician Assistant if the applicant:

- a. Remits the fees
- b. Is a graduate of an approved school and is scheduled to take the examination for Physician Assistant required by Wis. Admin. Code § MED 8.05(1) or has taken the examination and is awaiting the results; or

Except as specified in par. (b) above, a **temporary license expires when any of the following occurs:**

- The date the Board grants or denies an applicant permanent licensure.
- The date the applicant is notified that he/she has failed the national certifying examination.

NATIONAL EXAMINATION SCORES (not applicable to Re-registration applicants)

Scores must come directly from NCCPA. To make the request go to: www.nccpa.net and sign in to your online record. Click on "Credentialing Info Release" to submit your request to send exam scores to the Wisconsin Board.

Wisconsin Department of Safety and Professional Services

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

MEDICAL EXAMINING BOARD

APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

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

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

Mailing Address (if different) <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
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Social Security # <input type="text"/> - <input type="text"/> - <input type="text"/>	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.
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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

Email Address

School Name <input type="text"/>	School Address (street, city, state,) <input type="text"/>
Date Diploma Granted <input type="text"/> / <input type="text"/> / <input type="text"/>	Degree <input type="text"/>

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

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

Initial Credential
 \$ 75.00 Initial Credential Fee
 \$ 75.00 State Law Exam
 \$ 150.00 Total Fee Attached

Request for a Temporary License
 \$ 10.00 In addition to the above fee (non-refundable)

Re-Registration (licenses expired over five (5) years)
 \$ 75.00 Re-Registration Fee
 \$ 75.00 State Law Exam
 \$ 25.00 Late Renewal Fee
 \$ 175.00 Total Fee Attached

For Receiving Use Only (23)

Wisconsin Department of Safety and Professional Services

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

- Application (**Form #580**) and appropriate fee
- Letters from all State Boards where licensed, active and inactive
- Wisconsin Statutes and Rules Examination
- Certificate of Professional Education (**Form #1504**) (not applicable to Re-registration applicants)
- National Examination scores (go to: www.nccpa.net) (not applicable to Re-registration applicants)
- Malpractice Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, if applicable
- Convictions and Pending Charges (**Form #2252**), 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.”

PRACTICE: Account for all professional and nonprofessional activities and practice starting from the date of graduation to the present time. (attach additional sheet(s), if necessary)

Employer Name	Job Title and Job Duties (i.e. office staff, food service, PA, etc.)	Location Of Employer (City/State)	Dates Employed (Month/Year)
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 150px; height: 20px;" type="text"/> (State) <input style="width: 30px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 150px; height: 20px;" type="text"/> (State) <input style="width: 30px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 150px; height: 20px;" type="text"/> (State) <input style="width: 30px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>

Wisconsin Department of Safety and Professional Services

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

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

FOR TEMPORARY LICENSE: (not applicable to Re-registration applicants)

Check one:

- I plan to take the next National Certifying Examination on: / /
- I have taken and passed the National Certifying Examination.

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

1.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever failed to pass any state board examination, national board examination, or NCPPA examination? If yes, provide details on attached sheet	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you ever been convicted of a misdemeanor or a felony, or do you have any felony or misdemeanor charges pending against you? If yes, submit Convictions and Pending Charges (Form #2252).	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have any suits or claims ever been filed against you as a result of professional services? If yes, 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <input style="width: 650px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <input style="width: 650px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Wisconsin Department of Safety and Professional Services

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

"Ability to practice as a Physician Assistant" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned physician assistant judgments and to learn and keep abreast of physician assistant developments; and
2. The ability to communicate those judgments and physician assistant 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 as a Physician Assistant with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice as a Physician Assistant with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No

CERTIFICATION OF LEGAL STATUS:

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

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

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

Wisconsin Department of Safety and Professional Services

CONTINUING DUTY OF DISCLOSURE

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

AFFIDAVIT OF APPLICANT

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

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

Signature: Date: / /

Wisconsin Department of Safety and Professional Services

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

Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dps@wisconsin.gov
Website: <http://dps.wi.gov>

MEDICAL EXAMINING BOARD

RESPIRATORY CARE PRACTITIONER CERTIFICATION INFORMATION

All applicants shall pass the National Board for Respiratory Care (NBRC) examination and an open book examination on the Wisconsin Statutes and Administrative Code.

TEMPORARY CERTIFICATES:

An applicant for certification may apply to the Board for a Temporary Certificate to practice respiratory care if the applicant meets one of the following categories. If a review is required, the Temporary Certificate cannot be issued until the review is complete.

A. Graduate of Respiratory Care (new graduate):

- A new graduate may qualify for a Temporary Certificate if they have completed all requirements for licensure with the exception of taking and passing the NBRC examination.
- Practice during the period of the Temporary Certificate shall be in consultation, at least monthly, with a Respiratory Care Practitioner or a Physician who shall at least once a month endorse the activities of the person holding the Temporary Certificate.
- A Temporary Certificate will expire 90 days after the date of issuance, or upon notification of failure of the NBRC examination, whichever is sooner.

B. Certified Practitioners (individuals who hold a license in another state):

- An individual who currently holds an active license in another state may qualify for a Temporary Certificate if they have completed all requirements for licensure and DSPS is awaiting the receipt of their license verification from the State Board(s).
- A Temporary Certificate will expire 90-days after the date of issuance, and may not be renewed.

An applicant **may** be required to complete an oral examination if he/she:

1. has a medical condition which in any way impairs or limits the applicant's ability to practice respiratory care with reasonable skill and safety;
2. uses chemical substances so as to impair in any way the applicant's ability to practice respiratory care with reasonable skill and safety;
3. has been diagnosed as suffering from pedophilia, exhibitionism, or voyeurism;
4. has within the past 2-years engaged in the illegal use of controlled dangerous substances;
5. has been subject to adverse formal action during the course of respiratory care education, postgraduate training, hospital practice, or other respiratory care employment;
6. has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction;
7. has been convicted of a crime the circumstances of which substantially relate to the practice of respiratory care;
8. has not practiced respiratory care for more than 1,200 hours during the last 3-years prior to application;
9. has graduated from a respiratory care school not approved by the Board

An applicant who meets any of the above criteria 1-9 shall be reviewed by the Respiratory Care Practitioner Council to determine whether an applicant is required to complete an oral examination. If selected to appear for an oral examination, you will be advised of that date upon completion of your application.

Applicants required to complete an oral examination will be charged the fee of \$266.00.

An applicant who fails to receive a passing score on the NBRC examination and/or the Wisconsin Statutes and Rules examination three (3) times must submit a Remedial Education Plan to the Board for approval prior to re-scheduling the exam. An applicant for an oral examination may re-apply twice at not less than 4-month intervals.

Wisconsin Department of Safety and Professional Services

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

MEDICAL EXAMINING BOARD

APPLICATION FOR CERTIFICATION TO PRACTICE RESPIRATORY CARE

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK <input type="checkbox"/> Your name, address, telephone number, and email address are available to the public. Check box to withhold this information from lists of 10 or more credential holders (Wis. Stat. § 440.14).			
Last Name	First Name	MI	Former / Maiden Name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address (street, city, state, zip)		Daytime Telephone Number	
<input type="text"/>		<input type="text"/> - <input type="text"/> - <input type="text"/>	
Mailing Address (if different)		Date of Birth	
<input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>	
Social Security Number	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.		
<input type="text"/>			
Ethnicity/gender status information is optional.			
Ethnicity: <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian or Alaskan <input type="checkbox"/> Hispanic <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other			
Sex: <input type="checkbox"/> M <input type="checkbox"/> F			
Email Address			
<input type="text"/>			
Have you ever been licensed in Wisconsin as a Respiratory Care Practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list your credential number:			
<input type="text"/>			
School Name		School Address (street, city, state)	
<input type="text"/>		<input type="text"/>	
Date Diploma Granted		Degree	
<input type="text"/>		<input type="text"/>	

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

- I am seeking a Veteran Fee Waiver** (for Initial Credential Fee only, see page 2 for further information)
- Initial Credential**
 \$ 75.00 Initial Credential Fee
 \$ 75.00 State Law Exam
\$150.00 Total Fee Attached
- Request for a Temporary Certificate**
\$ 10.00 (is required in addition to the above fee and is non-refundable)
- Re-Registration of a Credential** (for late renewal after (5) five years)
 \$ 75.00 Renewal Fee
 \$ 25.00 Renewal Late Fee
 \$ 75.00 State Law Exam
\$175.00 Total Fee Attached

For Receiving Use Only (28)

Wisconsin Department of Safety and Professional Services

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

- Application (**Form #1790**) and appropriate fee
- Certificate of Professional Education (**Form #1792**), not applicable for re-registration
- Verification of Certification from the National Board for Respiratory Care: Order at nbrc.org or with the [NBRC Request for Credential Verification Form](#), not applicable for re-registration
- Verification of licensure from all State Boards where licensed, active and inactive
- Convictions and Pending Charges (**Form #2252**), if applicable
- Wisconsin Statutes and Rules Examination
- Request for a Temporary Certificate (**Form #1815**), for new graduates
- Request for a Temporary Certificate (**Form #2871**), for individuals who hold a license in another state
- Malpractice Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, if applicable
- Practice of Respiratory Care (**Form #1794**), not applicable for new graduates

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.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 "Professions," and "Respiratory Care Practitioner."

PRACTICE: Account for all activities and practice starting from the date of graduation to the present time. Must include professional and nonprofessional activities. All time and dates must be accounted for. (Attach additional sheets, if necessary.)

Employer Name and Location (City, State)	Job Title and Duties (i.e. office staff, food service, PA, etc.)	Hours	Dates Employed (Month/Year)
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time # of Hours/Week <input style="width: 100%;" type="text"/>	(From) <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time # of Hours/Week <input style="width: 100%;" type="text"/>	(From) <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time # of Hours/Week <input style="width: 100%;" type="text"/>	(From) <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time # of Hours/Week <input style="width: 100%;" type="text"/>	(From) <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>

Wisconsin Department of Safety and Professional Services

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.

TEMPORARY CERTIFICATE (Please check one of the following boxes.):

- I plan to take the next National Certifying Examination on:

--	--

 /

--	--

 /

--	--	--	--
- I have taken and passed the National Certifying Examination.
- I am licensed in another state and I have taken the National Certification Examination for Respiratory Care.

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

1.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever failed to pass any state board examination, national board examination, or NBRC examination? If yes, provide details below: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violations of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea or verdict? If yes, submit Convictions and Pending Charges form #2252.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have any suits or claims ever been filed against you as a result of professional services? If yes, 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Wisconsin Department of Safety and Professional Services

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned respiratory care judgments and to learn and keep abreast of respiratory care developments; and
2. The ability to communicate those judgments and respiratory care 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.

11.	Do you have a medical condition, which in any way impairs or limits your ability to practice respiratory care with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice respiratory care with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No

CERTIFICATION OF LEGAL STATUS:

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

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

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

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: / /