# Wisconsin Department of Safety and Professional Services

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## HEALTH CARE FACILITY NOTIFICATION OF TEMPORARY PROVIDER PRACTICE

**Interstate Reciprocity** - Pursuant to **State of Wisconsin Emergency Orders #16 and #20**, in response to the COVID-19 pandemic, a health care facility may utilize the practice of a health care provider with a valid and current unencumbered license issued in another state without the health care provider first obtaining a temporary or permanent license from DSPS. Please see the Orders and the DSPS website (dsps.wi.gov) for further information. **Email completed form to dsps@wisconsin.gov.**

**Name of Health Care Facility:**

**Address of Health Care Facility** (Street, City, State, Zip Code)**:**

**HEALTH CARE PROVIDER INFORMATION (Attach additional sheets in the same format if necessary.)**

| Name (Last, First, MI) | Profession (*List specialty, if applicable.*) | Other State Where Currently Licensed | Other State License Number | Start Date at Facility (mm/dd/yyyy) |
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**ATTESTATIONS – By signing below I attest to the following:**

1) The practice of each health care provider listed is necessary to ensure the continued and safe delivery of health care services at this health care facility.
2) This health care facility is hereby notifying DSPS within ten (10) days of each listed out-of-state health care provider practicing at this facility.
3) The health care facility's needs reasonably prevented in-state credentialing in advance of practice.
4) Each health care provider listed holds a valid and current license in another state and will be practicing within the scope of that license.
5) To the best of my knowledge and with a reasonable degree of certainty, each listed health care provider is not currently under investigation and does not currently have any restrictions or limitations placed on his or her license by the credentialing state or any other jurisdiction.
6) I acknowledge that each health care provider practicing under the above Orders must apply for a temporary or permanent health care license within thirty (30) days of first working at this health care facility.

**Printed Name** | **Title** | **Signature** | **Date** __/__/____



**Committed to Equal Opportunity in Employment and Licensing**