Wisconsin Department of Safety and Professional Services

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DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

FORM 2021-A102: HEALTH CARE EMPLOYER NOTIFICATION FOR 2021 WIS ACT 10 TEMPORARY CREDENTIAL

IMPORTANT NOTE: The expiration date of an active Wisconsin interstate reciprocity temporary credential issued pursuant to 2019 Wis. Act 185, Wisconsin Emergency Orders #2, #16, and #20, and/or Wisconsin Executive Order #90 will automatically be extended until 30 days after the national emergency declared by the U.S. president under 50 USC 1621 in response to the 2019 novel coronavirus ends. ***Providers holding an active temporary credential issued under any of the above provisions do not need to reapply.***

INSTRUCTIONS: This notification form is not required for health care providers providing services to patients located in Wisconsin only via telehealth. It also does not need to be resubmitted if a temporary credential was granted for a particular health care provider pursuant to 2019 Wis. Act 185 or any of the above-referenced Orders.

Health care employer, for purposes of this form, means a system, care clinic, care provider, long-term care facility, or any entity whose employed, contracted, or affiliated staff provide health care service to individuals in this state.

Submit this completed form to dspscredhealthcred@wisconsin.gov. **Form must be signed and submitted by health care employer staff (not health care provider).**

Name of Health Care Employer

Address of Health Care Employer (street, city, state, zip code)

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

Name (Last, First, MI)	**Profession** (*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.) I have confirmed that each provider identified on this form or via additional sheets holds a valid, unexpired credential granted by another state.
2.) To the best of my knowledge, and with a reasonable degree of certainty, each health care provider listed above or via additional sheets is not currently under investigation and no restrictions or limitations are currently placed on each health care provider's credential by the credentialing state or any other jurisdiction.

Printed Name **Title** **Signature** (Print and Sign Form) **Date** / /

Form must be signed and submitted by health care employer staff (not health care provider).