Wisconsin Department of Safety and Professional Services

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

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

DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

TELEMEDICINE PHYSICIAN NOTIFICATION OF HEALTHCARE PROVISION

An out-of-state physician who provides telemedicine in the diagnosis and treatment of a patient in Wisconsin pursuant to Wisconsin Emergency Order #2 who does not hold a valid Wisconsin license, must provide notice that they have provided healthcare to a Wisconsin resident within ten (10) days of the provision of healthcare to the Department of Safety and Professional Services (DSPS). The notice must be e-mailed to DSPS@wisconsin.gov and include verification of the physician's credentials. Notice need only be provided once. A physician solely providing care to patients in Wisconsin by telemedicine is not required to have his or her health care facility or system submit Form EO2020-2 or EO2020-4 regarding Notification of Practice. Forms and information are available under the "COVID-19 UPDATES & INFORMATION" section at dsps.wi.gov.

PLEASE TYPE OR PRINT IN INK ☐ Your name, address, telephone number, and e-mail address are available to the public. Check box to withhold address, telephone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

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

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __/__/____

E-mail Address

State/Canadian Province Where Licensed | **License Number** | **Expiration Date** __/__/____

License Type: ☐ **Regular (unlimited)** ☐ **Telemedicine** ☐ **Other, please specify:**

Start date of provision of telemedicine healthcare to a Wisconsin patient under Wisconsin Emergency Order #2 __/__/____

ANSWER THE FOLLOWING:

1.	Do you currently hold a valid and current license issued by another state or Canada? **If no, you are not eligible to practice telemedicine in Wisconsin under Wisconsin Emergency Order #2.**	☐ Yes ☐ No
2.	**If yes to Question 1**, are you currently under investigation or do you currently have any restrictions or limitations placed on your license by your credentialing state or any other jurisdiction? **If yes, you are not eligible to practice telemedicine in Wisconsin under Wisconsin Emergency Order #2.**	☐ Yes ☐ No
3.	I am aware that DSPS may withdraw an individual's authority to practice pursuant to Wisconsin Emergency Order #2 for good cause as determined by DSPS.	☐ Yes ☐ No
4.	I am aware that nothing in Wisconsin Emergency Order #2 should be construed to facilitate the practice by a credential-holder who has unmet disciplinary requirements, or whose credential has been suspended, revoked, or rescinded.	☐ Yes ☐ No
5.	I am aware that nothing in Wisconsin Emergency Order #2 prevents civil or criminal action against a person or entity who falsely reports required information to DSPS or practices without following the requirements of Wisconsin Emergency Order #2.	☐ Yes ☐ No
6.	I understand that where a requirement of Wis. Admin. Code ch. Med 24 applies to physicians licensed by the Wisconsin Medical Examining Board, such requirements also extend to my telemedicine practice in Wisconsin.	☐ Yes ☐ No
7.	I am aware that physician telemedicine practice under Wisconsin Emergency Order #2 is permissible until 30 days after the conclusion of the public health emergency, including any extensions.	☐ Yes ☐ No

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure while practicing under Wisconsin Emergency Order #2. If information I have provided in this notification form (#EO2020-6) becomes invalid, incorrect, or outdated, I understand that I am obliged to provide any necessary information to ensure the information in my notification form (#EO2020-6) remains current, valid, and truthful.

Wisconsin Department of Safety and Professional Services

AFFIDAVIT OF PHYSICIAN PROVIDING TELEMEDICINE

I declare that I am the person referred to on this notification form (#EO2020-6) 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 notification form (#EO2020-6) may result in penalties as provided by law. I further understand that I must comply with all applicable provisions of Wisconsin Emergency Order #2.

By signing below, I am signifying that I have read the above statements (Continuing Duty of Disclosure and Affidavit of Physician Providing Telemedicine) and understand the obligation I have while providing telemedicine to Wisconsin residents under Wisconsin Emergency Order #2 should information I've provided to the Department of Safety and Professional Services change.

Signature: _____ Date: __/__/____