

# Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way  
Madison, WI 53705  
Phone Number: (608) 266-2112

License Portal: <https://license.wi.gov/>  
Email: [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
Website: <http://dsps.wi.gov>

## CHIROPRACTIC EXAMINING BOARD EMPLOYER VERIFICATION (ENDORSEMENT APPLICANTS ONLY)

**APPLICANT:** Form is required for each employer where you engaged in the practice of chiropractic during the last five (5) years. Complete this section and forward to the employer. Form must be returned directly from the employer to the Department.

<b>Applicant Name:</b>	<input type="text"/>			
<b>Application Number:</b>	<input type="text"/>			
<b>Name of Employer:</b>	<input type="text"/>			
<b>Employer Address:</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	(number/street)	(city)	(state)	(zip code)
<b>Employer Phone:</b>	<input type="text"/>			

**ATTESTATION OF APPLICANT:** I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for 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. By signing below, I am signifying that I have read and understand the above declarations. I hereby authorize the school/course provider named below to provide the Department with the information requested below. I hereby authorize the school named below to provide the Department with the information requested below.

<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<b>Applicant Signature</b> (If unable to provide a digital signature, please print and sign form.)	<b>Date</b>

**EMPLOYER:** Complete this section for the above-named applicant and return directly to the Department using the License Third-Party\* Upload Portal at [license.wi.gov](https://license.wi.gov/). You will need the application number shown above. (\*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

**Employer must answer all of the following questions in order for this form to be considered complete.**

1. What position did this applicant hold at your facility or under your employment? <input type="text"/>
2. What were this applicant's dates of employment? (If applicant is still employed, check "to present" instead of "to" date.) From: <input type="text"/> / <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="checkbox"/> "to present"
3. How many hours per week did the applicant work at your facility? <input type="text"/> Hours per Week

*Continued on next page.*

# Wisconsin Department of Safety and Professional Services

*Employer completion, continued.*

**ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT:** I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

 /  / 

**Signature** (If unable to provide a digital signature, please print and sign form.)

**Date**

 -  -  Ext. \_\_\_\_\_

**Printed Name**

**Phone**

**Title**