Wisconsin Department of Safety and Professional Services

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Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

CERTIFICATE OF POSTGRADUATE TRAINING

(Not necessary if utilizing FCVS)

APPLICANT: Provide your name and application number and sign below. Forward this form to your postgraduate training program(s) for completion. Form must be returned directly from the postgraduate training program to the Department.

Applicant Name:	**Application Number:**

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 named below to provide the Department with the information requested below.

Applicant Signature (If unable to provide a digital signature, print and sign form.)	**Date** __/__/____

TRAINING PROGRAM: The Medical Examining Board requests that you complete this form concerning the applicant named above. Complete the remainder of the form and return directly to the Department using the LicensE Third-Party* Upload Portal at 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.)

Applicant/Physician's Name:	
Hospital/Program Name:	
Hospital/Program Address:	
Hospital/Program's Daytime Phone:	___ - ___ - ____

1. In what type and level(s) of training did this Physician participate at your facility? Indicate below each level of training in which the above-named Physician participated in your program. Provide start/end dates, type of training, and whether credit was given for the training.

DATES OF TRAINING (month/day/year)	**TYPE OF SPECIALTY TRAINING**	**FULL CREDIT**	**PARTIAL CREDIT**
PGY 1: __/__/____ to __/__/____		Yes ☐ No ☐	Yes ☐ No ☐
PGY 2: __/__/____ to __/__/____		Yes ☐ No ☐	Yes ☐ No ☐
PGY 3: __/__/____ to __/__/____		Yes ☐ No ☐	Yes ☐ No ☐
PGY 4: __/__/____ to __/__/____		Yes ☐ No ☐	Yes ☐ No ☐
Fellowship: __/__/____ to __/__/____		Yes ☐ No ☐	Yes ☐ No ☐
Transitional (Other): __/__/____ to __/__/____		Yes ☐ No ☐	Yes ☐ No ☐

Wisconsin Department of Safety and Professional Services

2.	Was the internship/residency/fellowship in the United States or Canada accredited by the Accreditation Council for Graduate Medical Education (ACGME, including ACGME-I), American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC)?	☐ Yes ☐ No
3.	Did the Physician either complete the training program in good standing, or is the Physician currently in the training program and in good standing? **If no, please attach explanation on a separate sheet**.	☐ Yes ☐ No
4.	Was this Physician recommended for the Board Certification Examination in this specialty? **If no, please provide a short explanation:**	☐ Yes ☐ No
If you answer Yes to questions 5-14, attach an explanation on a separate sheet.		
5.	Was the Physician asked, or required, to repeat any portion of the training program?	☐ Yes ☐ No
6.	Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while in the program? **If yes, please indicate if this constitutes an adverse formal action.**	☐ Yes ☐ No
7.	Was this Physician granted a leave of absence while in the training program?	☐ Yes ☐ No
8.	Did this individual have a record of unexcused absences during his/her attendance in this training program?	☐ Yes ☐ No
9.	Were any restrictions and/or special requirements placed on this Physician's activities that were not placed on all other residents/fellows at his/her level of training?	☐ Yes ☐ No
10.	Were any formal patient or staff complaints filed against this Physician?	☐ Yes ☐ No
11.	Were any incident reports filed involving the professional behavior or conduct of this Physician?	☐ Yes ☐ No
12.	Was this Physician ever subject to non-routine monitoring while in the training program?	☐ Yes ☐ No
13.	Were any malpractice actions filed naming this Physician as a defendant that involved his/her period of training in the program?	☐ Yes ☐ No
14.	Is there any additional information in this Physician's file that would assist the Board in determining this applicant's eligibility for licensure?	☐ Yes ☐ No
FOR PHYSICIANS CURRENTLY ENROLLED IN AN ACCREDITED POSTGRADUATE TRAINING PROGRAM:		
15.	Has the Physician completed and received credit for 12 consecutive months of postgraduate training in this program and does the Physician have the unrestricted endorsement from the postgraduate training director that the Physician is expected to complete at least 24 months of postgraduate training (Wis. Admin. Code § Med 1.02(3))? **If yes, please indicate the expected completion date of the 24 months of training:** __ __ / __ __ / __ __ __ __	☐ Yes ☐ No

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 of Dean or Department Head Date
(If unable to provide a digital signature, please print and sign form.)

_____ __ __ __ - __ __ __ - __ __ __ __ Ext_____

Printed Name **Phone**

_____

Title