Wisconsin Department of Safety and Professional Services

DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

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

INSTRUCTIONS: This notification form is not required for health care providers providing services to patients located in Wisconsin only via telehealth. Each health care provider listed on this form MUST submit an Act 10 online application via LicensE, https://license.wi.gov/. (See information sheet #2021-A101 for details.)

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.

Form must be signed and uploaded by health care employer staff (not health care provider). EMPLOYER: Upload completed form directly to the Department via the LicensE Third-Party* Upload Portal at https://license.wi.gov/. You will need each healthcare provider's LicensE Preliminary Application Reference (PAR) number to complete the upload. (*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.)

Name of Health Care Employer			
Address of Health Care Employer (number/street)	(city)	(state)	(zip code)

IMPORTANT: If the address above is an out-of-state address provide the name and address of the facility or system where this health care provider will provide services in Wisconsin. (This must be a Wisconsin address.)

Name of Wisconsin Facility or System			
Address of Health Care Employer (number/street)	(city)	(state)	(zip code)
		WI	

HEALTH CARE PROVIDER INFORMATION

Last Name	**First Name**	**Middle Name**

LicensE Preliminary Application Reference (PAR)	**State Where Licensed**	**Other State License Number**

Start Date for This Provider at the Facility(mm/dd/yyyy)	☐☐/☐☐/☐☐☐☐

ATTESTATIONS – By signing below I attest to the following:

1.	I have confirmed that the provider identified on this form holds a valid, unexpired credential granted by another state.
2.	To the best of my knowledge, and with a reasonable degree of certainty, the health care provider listed above 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.
3.	I declare, on behalf of the employer 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 print and sign form.)	**Date** (mm/dd/yyyy)
	☐☐/☐☐/☐☐☐☐
Printed Name	**Phone Number** (with area code)
Title	

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Committed to Equal Opportunity in Employment and Licensing