Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: (608) 266-2112

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

APPLICATION INFORMATION FORM

ATTENTION

IMPORTANT INFORMATION PLEASE READ

Enclosed is the application packet you recently requested from the Wisconsin Department of Regulation and Licensing.

To avoid any unnecessary errors, take a moment to review the entire application packet before you begin to complete your application.

We will mail you a check sheet within 10-15 *working* days after receipt of your application in this office. The check sheet will include an identification number that allows you to check the status of your application by calling the **Interactive Voice Response System, (608) 261-7925.** The Interactive Voice Response System will inform you of any requirements not met. You may also check the status of your application on our web-site: http://www.drl.state.wi.us. Look under "Applicant Services."

It is your obligation as an applicant to see that the items listed as "Is Required" are forwarded to the Department of Regulation and Licensing. The Department will not contact other agencies or jurisdictions for information/documents to complete your application. We will update check sheets within 3-5 working days *of receipt* of documents. An application is not considered complete until we receive all the required documents and fees.

Once your application is complete, check the department's web-site: http://www.drl.state.wi.us. Look under "Business/Professional License Lookup" for your official credential number and grant date.

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INFORMATION FOR COMPLETING MEDICINE AND SURGERY APPLICATION

MEDICAL EXAMINING BOARD

PLAN AHEAD:
Applicants, recruiters and institutions and others involved in the placement of individuals who seek to be credentialed in the state of Wisconsin should understand that the credentialing process **may take 30 to 60 days or more**, and that credentialing is not guaranteed to any applicant. Some factors that determine the length of time it may take to process an application depends on the length of time the applicant has been in practice, the total number of jurisdictions the applicant has been credentialed in and the length of time it takes for supporting documents to be received in the board office and reviewed.

The application consists of an all-inclusive packet with instructions and information on all applicable requirements. We attempt to process applications in a timely fashion. We cannot issue a credential until all the required documents have been received and reviewed in the board office. It is the Department's legislative mandate to provide consumer protection for Wisconsin residents.

The Bureau and the Board have been prevailed upon to waive requirements to expedite the process, only to discover legitimate grounds to deny a credential. This can present a serious problem for the applicant, recruiter or institutions if the applicant has relocated, purchased property, or made other commitments prior to the issuance of a Wisconsin credential. **We urge you not to make these moves until you know that your credential has been issued.**

Please "plan ahead" as we cannot speed up the credentialing process nor waive supporting documents even in emergency situations.

PLEASE READ BEFORE COMPLETING YOUR APPLICATION:
Enclosed is an application for a license to practice medicine and surgery in the State of Wisconsin. Please check the appropriate square on the bottom of page one of "Application for License to Practice Medicine and Surgery" (Form #570) to indicate the basis by which you are applying for a license and attach the required fee made payable to Regulation and Licensing. You are required to supply evidence that you have completed 12 months of postgraduate training in a facility approved by the board.

FEDERATION CREDENTIALS VERIFICATION SERVICE:
The Department of Regulation and Licensing will accept a physician information profile completed by the Federation Credentials Verification Service (FCVS). This service is through the Federation of State Medical Boards. However, if this is the first time you are utilizing this service, it may take 4 to 6 weeks longer instead of utilizing our Department state forms. You may obtain this service online, website www.fsmb.org. If you utilize this service (FCVS), you will **not** have to use our forms to verify your medical school education (#2164), post-graduate training (#2165), licensure exam scores (EBAHR), board action information (#1445), or provide a copy of your medical diploma or ECFMG certificate.

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Application (Form #570)	Copies of malpractice suit. Court documents with allegations and settlement.
Copy of ECFMG certificate if a Foreign Graduate (FCVS)	Letters from all State Boards where licensed (includes active and inactive licenses) (See page 3 of Application Form for instructions)
Copy of Professional Diploma and translation if necessary (FCVS)	Signed Authorization and Waiver Form (Form #571)
Medical Education Verification Form (Form #2164 (FCVS)	Physician Profile Data Report from the American Medical Association, or American Osteopathic Association
Certificate of Post-graduate Training (Form #2165 (FCVS)	Disciplinary Inquiry Report from the Federation of State Medical Boards (Form #1445) (FCVS)
National Board, FLEX, State Board, USMLE or LMCC score (FCVS)	Fee attached to application (Form #570)
Employment Verification Form (Form #2166)	Wisconsin Statutes and Rules Examination Booklet with answer sheet
Work History (Form 1934)	Convictions & Pending Charges Form, if applicable
National Practitioner Data Bank Report	
Hospital Verification-Privileges, Employment or Appointment (Form #2167)	

Committed to Equal Opportunity in Employment and Licensing

State of Wisconsin Department of Regulation & Licensing

ENDORSEMENT CANDIDATES:

Endorsement of FLEX and/or USMLE:

a) Endorsement of the FLEX examination (Wisconsin requires that **prior to June 1985 you must have taken FLEX all three (3) days at one sitting AND obtained a FLEX weighted average of 75%. After June 1985, Wisconsin requires a passing score of 75% in Component 1 and 75% in Component 2)**,

b) Endorsement of FLEX Component 1 and USMLE Step 3, or

c) Endorsement of USMLE Steps 1, 2 and 3.

Complete the enclosed "Examination and Board Action History Report" or you may wish to electronically obtain at FSMB's website www.fsmb.org and go to Transcript Request section located on FSMB's main website page.

Endorsement of National Boards and/or USMLE: (United States graduates)

a) Part I, II & III of National Boards, or
"Request for Endorsement of NBME Certification" forms are available on the internet. World Wide Web address: **http:// www.nbme.org.**

b) Part I, II of National Boards and USMLE Step 3.
"Request for Endorsement of NBME Certification" forms are available on the internet. World Wide Web address: **http:// www.nbme.org.**

Endorsement of National Boards I & II for ECFMG Certification and Step 3 of USMLE: (Foreign Graduates)

You are required to contact ECFMG, 3624 Market St., Philadelphia, PA 19104-2685 to request certified National Boards I & II subjects and scores and a historical record of these exams. Exams must have been taken after 9/89. ECFMG should forward this information directly to the Board office. There is no fee for certification requests from ECFMG.

Complete the enclosed "Examination and Board Action History Report" form to request USMLE Step 3 scores or you may wish to electronically obtain at FSMB's website www.fsmb.org and go to Transcript Request section located on FSMB's main website page.

Endorsement of the National Board of Osteopathic Medical Examiners Certification:

Mail your request for "Endorsement of Certification/Official Transcript" form and fee to the National Board of Osteopathic Medical Examiners, (773) 714-0622, www.nbome/org/. Transcripts must be mailed directly to the Wisconsin Medical Examining Board office.

Endorsement of LMCC:

LMCC examination must have been taken after 1/1/78. Direct certification from the Medical Council of Canada is required.

Reciprocity of State Board Exam Taken Prior to 1972:

Scores must be certified by the State Board and sent directly to this office. The State Board must indicate the subjects covered in the examination, the scores received, the general average, the date of the examination, your license number and date of issuance, your status of licensure, information pertaining to disciplinary action, and the board seal.

Verification of Other Medical Licenses is Required:

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN LICENSED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN MEDICAL EXAMINING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, LICENSE NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE.

State of Wisconsin Department of Regulation & Licensing

USMLE STEP 3 EXAMINATION CANDIDATES:
Candidates are required to write both days of the examination. You will not be permitted to write Step 3 of USMLE in Wisconsin unless you are also applying for a license to practice medicine and surgery in the State of Wisconsin.

Prior to writing USMLE Step 3, a candidate must have successfully completed:

- USMLE Step 1 and Step 2, **or**
- Part I and Part II of the National Boards, **or**
- FLEX Component 1, **and**
- Successfully complete twelve months of postgraduate/internship training in an approved facility within 60 days of desired examination date.

If you have **failed to pass** any of these examinations **in three or more attempts**, you must submit evidence of further professional training or education in examination areas in which you had previously demonstrated deficiencies. This evidence will be reviewed by the board prior to being admitted to the USMLE Step 3 examination.

1. Your "Application for Licensure to Practice Medicine and Surgery" (Form #570), **with all supporting documents** listed on page two of Form #570, **MUST BE RECEIVED** in the Board office **before we will forward your "USMLE Step 3 Application" to the Federation of State Medical Boards.**
2. Complete the enclosed "USMLE Step 3 Application" and submit with your "Application for Licensure to Practice Medicine and Surgery" (Form #570).
3. Request scores for the USMLE Steps 1 and 2, National Board, or FLEX. These scores must be received in the board office before we will forward your "USMLE Step 3 Application" to the Federation of State Medical Boards.

NATIONAL PRACTITIONER DATA BANK:
First year US/Canadian postgraduate training candidates who have just completed their first year (no more than 2 months prior to application for licensure) are exempt. All other candidates must request the "Practitioner Request for Information Disclosure" (Self-Query) from the National Practitioner Data Banks web site www.npdb-hipdb.com/. **OPEN THE ENVELOPE** and check to be certain your application was accepted. When accepted, mail the **ORIGINAL** to the Medical Examining Board at the address below. Further questions regarding this form may be directed to the Data Bank Help Line at 1-800-767-6732.

ORAL EXAMINATIONS:
The oral examination process in the State of Wisconsin was revised effective May 1, 1987. New rules created under MED 1.06 of the Administrative Code read as follows:

Panel Review: Oral and written examinations.

a) All applicants shall complete a written examination. In addition, an applicant **may** be required to complete an oral examination if the applicant:

   1. Has a medical condition which in any way impairs or limits the applicant's ability to practice medicine and surgery with reasonable skill and safety.
   2. Uses chemical substances so as to impair in any way the applicant's ability to practice medicine and surgery with reasonable skill and safety.
   3. Has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction.
   4. Has been found to have been negligent in the practice of medicine or has been a party in a lawsuit in which it was alleged that the applicant had been negligent in the practice of medicine.
   5. Has been convicted of a crime the circumstances of which substantially relate to the practice of medicine.
   6. Has lost, had reduced or had suspended his or her hospital staff privileges, or has failed to continuously maintain hospital privileges during the applicant's period of licensure following post-graduate training.
   7. Has been graduated from a medical school not approved by the board.
   8. Has been diagnosed as suffering from pedophilia, exhibitionism or voyeurism.
   9. Has within the past 2 years engaged in the illegal use of controlled substances.
   10. Has been subject to adverse formal action during the course of medical education, postgraduate training, hospital practice, or other medical employment.

11. Has not practiced medicine and surgery for a period of 3 years prior to application, unless the applicant has been graduated from a school of medicine within that period.

b) An application filed under s. Med 1.02 shall be reviewed by an application review panel of at least 2 board members designated by the chairperson of the board. The panel shall determine whether the applicant is eligible for a regular license without completing an oral examination.

An applicant can also be required to take an oral examination under Med 1.08(2), if the applicant has been examined four or more times before achieving a passing grade.

If you are selected to appear for an oral examination, an additional examination fee will be required prior to being scheduled for the oral examination. You will be scheduled to appear before the review panel at one of the regularly scheduled board meetings.

ALL CANDIDATES are required to take an open book examination on Wisconsin Statutes and Rules relating to the practice of medicine in this state. Enclosed is a numbered examination booklet along with an answer sheet. **Write the booklet number on the answer sheet. You must return the entire examination booklet and answer sheet to this office.** If you fail this open book examination, an additional fee will be required for you to retake it.

FOREIGN GRADUATES:

ECFMG Certificate: Graduates of foreign medical schools must provide a copy of an ECFMG certificate with "valid indefinitely" status.

Fifth Pathway Certificate: If you participated in a 5th Pathway program, you must submit a copy of your 5th Pathway certificate from the program you attended.

Certificate of Professional Education: The only document accepted by the Board in lieu of the "Certificate of Professional Education" is an **original** letter signed by the Dean or Registrar which indicates the degree received and the date the degree was conferred.

OTHER REQUIRED FORMS:

1. Request physician profile data report from the American Medical Association or the American Osteopathic Association.
2. If not using FCVS, request disciplinary inquiry report from Federation of State Medical Boards (Form #1445).

LOCUM TENENS:

A Locum Tenens license may be issued to a candidate who intends only to practice medicine and surgery in Wisconsin for a 90-day period or less. However, the application process is almost identical in processing time and documentation requirements to that for the permanent license.

Eligibility: Applicants must hold a current license to practice medicine and surgery in another jurisdiction of the United States or Canada.

All applicants are required to complete the same application packet as applicants applying for a permanent license, with the following additional requirements:

1) a letter requesting services from a physician licensed in Wisconsin including starting and ending date;
2) notarized copy of an original wall certificate of licensure; and
3) a notarized copy of a current registration card to practice medicine and surgery in another jurisdiction of the United States or Canada.

After your completed application is received in the medical board office, it will be reviewed by two members of the Board. Upon approval you will be issued a Locum Tenens license number, which is good for 90 days.

MAILING INSTRUCTIONS:

Mail the "Application for Licensure to Practice Medicine and Surgery" (Form #570), the appropriate fee, examination booklet, answer sheet, and documentation to the following address:

MAILING ADDRESS:
DEPARTMENT OF REGULATION & LICENSING
MEDICAL EXAMINING BOARD
P.O. BOX 8935
MADISON WI 53708-8935

EXPRESS DELIVERY:
DEPARTMENT OF REGULATION & LICENSING
MEDICAL EXAMINING BOARD
1400 E. WASHINGTON AVE
MADISON WI 53703

State of Wisconsin Department of Regulation & Licensing

CODES FOR SPECIALTIES:

ENTER **ONLY ONE** SPECIALTY CODE ON THE "APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY" (FORM #570)

Academic Medicine	37
Administrative Medicine	71
Aerospace Medicine	33
Alcoholism - Chemical Dependency	49
Allergy - Immunology	01
Anesthesiology	02
Aviation Medicine	32
Dermatology	03
Emergency Medicine	31
Endocrinology	56
Family Practice	41
Gastroenterology	06
General Practice	08
Genetics	61
Geriatrics	29
Hand Surgery	64
Hebiatrics	46
Hematology	07
Hyperbaric Medicine	65
Immunology - Infectious Diseases	47
Institutional Medicine	39
Internal Medicine	04
Internal Medicine - Cardiology	05
Internal Medicine - Pulmonary Medicine	45
Neonatology	63
Nephrology	40
Neurology	10
Neurophysiology	51
Nuclear Medicine	23
Obstetrics and Gynecology	12
Occupational Medicine	30
Oncology	38
Ophthalmology	13
Orthopedic Surgery	14
Otolaryngology	67
Otorhinolaryngology - Ent	15
Pain	66
Pathology	16
Pathology - Clinical	17
Pathology - Surgical Anatomic	72
Pediatrics	18
Pediatrics - Other	60
Perinatology	62
Pharmacology - Clinical	48
Physical Medicine and Rehabilitation	19
Preventive Medicine	09
Proctology	36
Psychiatry	20
Psychiatry - Child	21
Public Health	22
Radiation - Oncology	70
Radiology	53
Radiology - Diagnostic	43
Radiology - Nuclear Medicine	68
Radiology - Ultrasound	69
Research	34
Retired	24
Rheumatology	57
School Physician	52
Surgery - Cardiovascular	44
Surgery - Colon and Rectal	54
Surgery - General	25
Surgery - Maxillofacial	58
Surgery - Neurological	11
Surgery - Peripheral Vascular	59
Surgery - Plastic	26
Surgery - Thoracic	27
Urology	28

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NOTICES

TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.[a] An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

PROCEDURES ON APPLICATION DENIAL

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at *http://www.legis.state.wi.us/rsb/code/rl/rl.html* and may also be obtained from the department.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at *http://www.drl.state.wi.us/* under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

AMERICANS WITH DISABILITIES ACT

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Communications and examinations: Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 11/19/02) ss. 15.04 (1) (m), 19.35, Stats.

[a] Section RL 4.06 of the Wisconsin Administrative Code

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APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY

MEDICAL EXAMINING BOARD

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

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

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth
_____ month _____ day _____ year

Daytime Telephone Number
( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Select only one code.
See list attached.

Medical School: _____

School Address: _____
(City) (State)

Degree: _____

Specialty: _____

Specialty Code: _____

Date Degree Granted: _____
month/day/year

APPLICATION FEES Please check only **one** blank: (Make check payable to Department of Regulation and Licensing and attach to application.)

_____ **To Write PART III USMLE**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 15.00 Contract Exam Fee
$ 125.00 Total Fee Attached*

_____ **Endorsement of National Boards (MD or DO)**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 110.00 TOtal Fee Attached*

_____ **Endorsement of FLEX**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 110.00 Total Fee Attached*

_____ **Reciprocity of State Board Exam**
(Taken Prior to 1972)*
$ 106.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 163.00 Total Fee Attached*

_____ **Endorsement of LMCC**
(Taken after 1/1/78)
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 110.00 Total Fee Attached*

_____ **Endorsement of Steps 1, 2, & 3 of USMLE**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 110.00 Total Fee Attached*

_____ **LOCUM TENENS***
$ 106.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 163.00 Total Fee Attached*

For Receipting Use Only

***ORAL EXAMINATION FEE: $266.00**
If you should be selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for the exam.

#570 (Rev. 03/03)
Ch. 448, Stats.

Committed to Equal Opportunity in Employment and Licensing

State of Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- Application (Form #570)
- Copy of ECFMG certificate if a Foreign Graduate (FCVS)
- Copy of Professional Diploma and translation if necessary (FCVS)
- Medical Education Verification Form (Form #2164 (FCVS)
- Certificate of Post-graduate Training (Form #2165 (FCVS)
- National Board, FLEX, State Board, USMLE or LMCC score (FCVS)
- Employment Verification Form (Form #2166)
- Work History (Form 1934)
- National Practitioner Data Bank Report
- Hospital Verification-Privileges, Employment or Appointment (Form #2167)
- Copies of malpractice suit. Court documents with allegations and settlement.
- Letters from all State Boards where licensed (includes active and inactive licenses) (See page 3)
- Signed Authorization and Waiver Form (Form #571)
- Physician Profile Data Report from the American Medical Association or American Osteopathic Association
- Disciplinary Inquiry Report from the Federation of State Medical Boards (Form #1445) (FCVS)
- Fee attached to application (Form #570)
- Wisconsin Statutes and Rules Examination Booklet with answer sheet
- Convictions & Pending Charges Form, if applicable

IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

PRE-PROFESSIONAL EDUCATION: (schools, locations, dates of graduation and degrees) (list all schools attended)

	SCHOOL	DEGREE	DATES OF GRADUATION
1.			
2.			
3.			
4.			

PROFESSIONAL EDUCATION: (schools, locations, dates of graduation and degrees) (list all schools attended)

	SCHOOL	DEGREE	DATES OF GRADUATION
1.			
2.			
3.			
4.			

POST-GRADUATE TRAINING AND FELLOWSHIPS: Outline in chronological order. (Attach additional sheets if necessary)

	NAME OF HOSPITAL OR CLINIC	LOCATION	DATES (from - to) mo/yr
1.			
2.			
3.			
4.			

PRACTICE AND OTHER ACTIVITIES: Outline in chronological order from the date of completion of your training/fellowship to the present time. Must include professional and nonprofessional activities. All activities must be accounted for. (Attach additional sheets if necessary.)

	NAME OF HOSPITAL OR CLINIC	LOCATION	DATES (from - to) mo/yr
1.			
2.			
3.			
4.			
5.			

(attach additional sheets if necessary)

ECFMG EXAM TAKEN	CERTIFICATE ISSUED	CERTIFICATE NO.	DATE ISSUED
_____ Yes _____ No	_____ Yes _____ No	_____	_____

SPECIALTY BOARD CERTIFICATIONS DATE CERTIFIED

State of Wisconsin Department of Regulation & Licensing

LIST ALL HOSPITALS THAT YOU HAVE HAD STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENTS DURING THE LAST 5 YEARS:

	NAME OF HOSPITAL	LOCATION	DATES (from-to) mo/yr/
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

I AM CURRENTLY OR HAVE BEEN LICENSED IN THE FOLLOWING STATES (UNLIMITED): INCLUDE ACTIVE AND INACTIVE CREDENTIALS.

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN LICENSED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN MEDICAL EXAMINING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, LICENSE NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE.

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.

		YES	NO
1.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	☐	☐
2.	Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	☐	☐
3.	Have you ever failed to pass any state board examination, national board examination, or USMLE, or FLEX examination? If yes, give details on an attached sheet.	☐	☐
4.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	☐	☐
5.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	☐	☐
6.	Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
7.	Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)	☐	☐
8.	Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	☐	☐

State of Wisconsin Department of Regulation & Licensing

		YES	NO
9.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	❑	❑
10.	Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet.	❑	❑
11.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	❑	❑
12.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	❑	❑
13.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	❑	❑

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

		YES	NO
14.	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	❑	❑
15.	Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	❑	❑
16.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	❑	❑
17.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	❑	❑
18.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	❑	❑
19.	Are you currently engaged in the illegal use of controlled dangerous substances?	❑	❑
20.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	❑	❑

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this application and that all the statements herein contained are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential or other disciplinary action. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Medical Examining Board or the Department of Regulation and Licensing will be cause for disciplinary action.

_____
Signature of Applicant

State of _____ County of_____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____
Signature of Notary Public

SEAL

_____
Date Commission Expires

NOTE: THIS AFFIDAVIT MUST BE SIGNED BY THE APPLICANT BEFORE THE NOTARY ON THE SAME DATE.

State of Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name _____ Middle Initial _____ Last Name _____

Profession _____

Date of Birth _____ month _____ day _____ year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.
[2] Sections 49.22, and 440.13, Wis. Stats.
[3] Section 440.12, Wis. Stats.
[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

MEDICAL EDUCATION VERIFICATION FORM

MEDICAL EXAMINING BOARD

(Not necessary if utilizing FCVS)

IMPORTANT: *PLEASE FORWARD THIS FORM TO YOUR MEDICAL SCHOOL*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

APPLICANT'S NAME: _____ Soc. Sec. #* _____

MEDICAL SCHOOL: _____

MEDICAL SCHOOL ADDRESS: _____

		YES	NO
1.	Did this physician attend the medical school noted above?	☐	☐
2.	What were the applicant's dates of enrollment in this medical school? _____		
3.	Did this physician graduate from this medical school? If no, please attach explanation on a separate sheet.	☐	☐
	Degree Granted _____ Date Degree Granted _____		
4.	Did this individual take a leave of absence during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet.	☐	☐
5.	Did this individual have a record of unexcused absences during his/her attendance at this medical school?	☐	☐
6.	Was this individual ever disciplined or under investigation during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet.	☐	☐
7.	Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? If yes, please attach explanation on a separate sheet.	☐	☐
8.	Was this individual recommended for post-graduate training?	☐	☐

Print name of Dean _____

Signature of Dean _____

Date form was completed _____

*For use in school locating your records

SEAL OF MEDICAL SCHOOL

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

#2164 (Rev. 12/27/02)
Ch. 448, Stats.

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

CERTIFICATE OF POSTGRADUATE TRAINING

MEDICAL EXAMINING BOARD

(Not necessary if utilizing FCVS)

IMPORTANT: *PLEASE FORWARD THIS FORM TO YOUR POSTGRADUATE TRAINING PROGRAMS (This form may be photocopied)*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: _____

HOSPITAL NAME: _____

HOSPITAL ADDRESS: _____

HOSPITAL TELEPHONE: _____

1. In what type and level(s) of training did this physician participate at your facility? Check each level in which physician participated, provide starting and ending dates of his/her training in your program and type of training and whether credit was given for the training.

DATES (MO/YR)	SPECIALTY	CREDIT	NO CREDIT	PARTIAL CREDIT
_____ PGY 1 _____				
_____ PGY 2 _____				
_____ PGY 3 _____				
_____ PGY 4 _____				
_____ FELLOWSHIP _____				
_____ OTHER _____				

	YES	NO
2. Was the residency/fellowship accredited by ACGME of the AMA or AOA?	☐	☐
3. Did the physician complete the full training program in good standing? If no, please attach explanation on a separate sheet.	☐	☐
4. Was the physician asked to or required to repeat any portion of the training at your facility? If yes, please attach explanation on a separate sheet.	☐	☐

State of Wisconsin Department of Regulation & Licensing

		YES	NO
5.	Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
6.	Was this physician recommended for the Board Certification examination in this specialty?	☐	☐
7.	Was this physician granted a leave of absence while training at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
8.	Did this individual have a record of unexcused absences during his/her attendance at this training program?	☐	☐
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? If yes, please attach explanation on a separate sheet.	☐	☐
10.	Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet.	☐	☐
11.	Were any incident reports filed involving the professional behavior or conduct of this physician? If yes, please attach explanation on a separate sheet.	☐	☐
12.	Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
13.	Were any malpractice actions filed naming this physician as a defendant that involved his/her period of training at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
14.	Is there any additional information in this physician's file that would assist the Board in determining this applicant's eligibility for licensure. If yes, please attach explanation on a separate sheet.	☐	☐

Print name of Program Director _____

Signature of Program Director _____

Date form was completed _____

SEAL OF HOSPITAL

(If hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate)

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
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1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

EMPLOYMENT VERIFICATION FORM FOR EMPLOYERS OTHER THAN HOSPITALS

MEDICAL EXAMINING BOARD

IMPORTANT: *PLEASE FORWARD THIS FORM TO ALL EMPLOYERS DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S TELEPHONE: _____

1. What position did this physician hold when employed by you? _____

2. What were this physician's dates of employment? _____

	YES	NO
3. Did this physician leave your employ in good standing? If no, please attach explanation on a separate sheet.	☐	☐
4. Was the physician on probation, suspended or in any way sanctioned/disciplined while employed by you? If yes, please attach explanation on a separate sheet.	☐	☐
5. Was this physician granted a leave of absence while employed by you? If yes, please attach explanation on a separate sheet.	☐	☐
6. Were any restrictions or special requirements placed on this physician's activities which were not placed on all other employees holding similar positions? If yes, please attach explanation on a separate sheet.	☐	☐
7. Was this physician denied hospital privileges while employed by you? If yes, please attach explanation on a separate sheet.	☐	☐
8. Were any restrictions or special requirements placed on this physician's hospital privileges? If yes, please attach explanation on a separate sheet.	☐	☐
9. Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet.	☐	☐

State of Wisconsin Department of Regulation & Licensing

	YES	NO
10. Were any incident reports filed involving the professional conduct or behavior of this physician? If yes, please attach explanation on a separate sheet.	☐	☐
11. Was this physician ever subject to a non-routine monitoring while in your employ? If yes, please attach explanation on a separate sheet.	☐	☐
12. Was this physician removed from a call schedule for cause? If yes, please attach explanation on a separate sheet.	☐	☐

Print name of Employer Supplying Information _____

Signature of Employer Supplying Information _____

Date form was completed _____

PLEASE ATTACH LETTERHEAD FROM THE FACILITY WHERE THE APPLICANT WORKED OR SUPPLY SOME FORM OF IDENTIFICATION FOR INDIVIDUAL SUPPLYING INFORMATION.

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Department of Regulation & Licensing

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Madison, WI 53708-8935
FAX #: (608) 261-7083
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Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

WORK HISTORY
MEDICINE AND SURGERY

MEDICAL EXAMINING BOARD

COMPLETE WORK HISTORY. If you have never been employed, stop at box 7. Photocopy this form if additional space is required.

1. NAME / LAST **FIRST** **MI**		**2. DATE OF BIRTH** ___ ___ / ___ ___ / ___ ___
3. ADDRESS (Street, City, State, Zip Code)		
4. MAIDEN OR GIVEN SURNAME	**5. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED:** _____	**6. DATE FORM COMPLETED:**

7. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation from medical school. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS INSTITUTION:	**JOB TITLE:**
ADDRESS: (Street, City, State, Zip Code)	**DESCRIPTION OF DUTIES PERFORMED:**
SUPERVISOR NAME: _____	
DATE OF EMPLOYMENT/ ATTENDANCE: From: ___ ___ / ___ ___ / ___ ___ (Month Day Year) To: ___ ___ / ___ ___ / ___ ___ (Month Day Year)	**HOURS WORKED PER WEEK:** _____ **TYPE OF EMPLOYMENT:** _____ Full-time _____ Part-time
TOTAL TIME WORKED (Yr./Mo.)	

B. NAME OF BUSINESS INSTITUTION:	**JOB TITLE:**
ADDRESS: (Street, City, State, Zip Code)	**DESCRIPTION OF DUTIES PERFORMED:**
SUPERVISOR NAME: _____	
DATE OF EMPLOYMENT/ ATTENDANCE: From: ___ ___ / ___ ___ / ___ ___ (Month Day Year) To: ___ ___ / ___ ___ / ___ ___ (Month Day Year)	**HOURS WORKED PER WEEK:** _____ **TYPE OF EMPLOYMENT:** _____ Full-time _____ Part-time
TOTAL TIME WORKED (Yr./Mo.)	

State of Wisconsin Department of Regulation & Licensing

C. NAME OF BUSINESS INSTITUTION:	JOB TITLE:
ADDRESS: (Street, City, State, Zip Code)	DESCRIPTION OF DUTIES PERFORMED:
SUPERVISOR NAME: _____	
DATE OF EMPLOYMENT/ ATTENDANCE: From: ___ ___ / ___ ___ / ___ ___ Month Day Year To: ___ ___ / ___ ___ / ___ ___ Month Day Year	HOURS WORKED PER WEEK: _____ TYPE OF EMPLOYMENT: _____ Full-time _____ Part-time
TOTAL TIME WORKED (Yr./Mo.)	
D. NAME OF BUSINESS INSTITUTION:	JOB TITLE:
ADDRESS: (Street, City, State, Zip Code)	DESCRIPTION OF DUTIES PERFORMED:
SUPERVISOR NAME: _____	
DATE OF EMPLOYMENT/ ATTENDANCE: From: ___ ___ / ___ ___ / ___ ___ Month Day Year To: ___ ___ / ___ ___ / ___ ___ Month Day Year	HOURS WORKED PER WEEK: _____ TYPE OF EMPLOYMENT: _____ Full-time _____ Part-time
TOTAL TIME WORKED (Yr./Mo.)	
E. NAME OF BUSINESS INSTITUTION:	JOB TITLE:
ADDRESS: (Street, City, State, Zip Code)	DESCRIPTION OF DUTIES PERFORMED:
SUPERVISOR NAME: _____	
DATE OF EMPLOYMENT/ ATTENDANCE: From: ___ ___ / ___ ___ / ___ ___ Month Day Year To: ___ ___ / ___ ___ / ___ ___ Month Day Year	HOURS WORKED PER WEEK: _____ TYPE OF EMPLOYMENT: _____ Full-time _____ Part-time
TOTAL TIME WORKED (Yr./Mo.)	

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

HOSPITAL VERIFICATION - PRIVILEGES, EMPLOYMENT OR APPOINTMENT

MEDICAL EXAMINING BOARD

IMPORTANT: *PLEASE FORWARD THIS FORM TO ALL HOSPITALS THAT YOU HAVE HAD STAFF PRIVILEGES DURING THE LAST 5 YEARS (This form may be photocopied).*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: _____

HOSPITAL/FACILITY: _____

HOSPITAL/FACILITY ADDRESS: _____

HOSPITAL/FACILITY TELEPHONE: _____

1. What position did this physician hold at your facility? _____

2. What were this physician's dates of employment or staff privileges at your facility? _____

	YES	NO
3. Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
4. Was this physician granted a leave of absence while employed at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
5. Did this individual have a record of unexcused absences during his/her attendance at this facility?	☐	☐
6. Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees/staff holding similar positions? If yes, please attach explanation on a separate sheet.	☐	☐
7. Were any restrictions placed on this physician's privileges? If yes, please attach explanation on a separate sheet.	☐	☐
8. Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet.	☐	☐
9. Were any incident reports filed involving the professional conduct or behavior of this physician? If yes, please attach explanation on a separate sheet.	☐	☐

State of Wisconsin Department of Regulation & Licensing

		YES	NO
10.	Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
11.	Was this physician involuntarily removed from a call schedule for cause? If yes, please attach explanation on a separate sheet.	☐	☐
12.	Was this physician subject to non-routine quality assessment review? If yes, please attach explanation on a separate sheet.	☐	☐
13.	Was this physician the subject of a negative review by a quality assurance or departmental committee? If yes, please attach explanation on a separate sheet.	☐	☐

Name and Title of Certifying Official

Date

SEAL OF HOSPITAL
(If hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this certificate)

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 261-7083
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Madison, WI 53703

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

MEDICAL EXAMINING BOARD

BOTH FORMS MUST BE SIGNED AND NOTARIZED IN BOTH SPACES PROVIDED

AUTHORIZATION AND WAIVER

_____ Name _____ City/State/Country of Birth _____ Date of Birth

having filed an application for a license to practice medicine and surgery in the State of Wisconsin, hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

I also authorize and request every person, hospital, clinic, community, governmental agency, court, association or institution having control of any documents, records and other information pertaining to me, to furnish to the Wisconsin Medical Examining Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any of its pertinent data and to permit the Wisconsin Medical Examining Board or any of its agents or representatives to inspect and make copies of such documents, records and other information.

I hereby release, discharge, exonerate the Wisconsin Medical Examining Board, its agents and representatives, and any person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information or the investigation made by the Wisconsin Medical Examining Board.

_____
Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____ Signature of Notary Public _____ Date Commission Expires

AUTHORIZATION AND WAIVER

_____ Name _____ City/State/Country of Birth _____ Date of Birth

having filed an application for a license to practice medicine and surgery in the State of Wisconsin, hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

I also authorize and request every person, hospital, clinic, community, governmental agency, court, association or institution having control of any documents, records and other information pertaining to me, to furnish to the Wisconsin Medical Examining Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any of its pertinent data and to permit the Wisconsin Medical Examining Board or any of its agents or representatives to inspect and make copies of such documents, records and other information.

I hereby release, discharge, exonerate the Wisconsin Medical Examining Board, its agents and representatives, and any person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information or the investigation made by the Wisconsin Medical Examining Board.

_____
Signature of Applicant

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____ Signature of Notary Public _____ Date Commission Expires

American Medical Association

Physicians dedicated to the health of America

AMA Physician Profile Unit
515 North State St
Chicago, IL 60610

Telephone: 312 464-5199
Fax: 312 464-5900

AMA Physician Profile Order Form -- Physician Use Only

Complete and send this form to the American Medical Association (AMA) at the above address. Profiles also can be ordered online through ***AMA ePhysician Profiles*** located at http://www.ama-assn.org/AMAPhysicianProfiles. AMA Customer Service is available for ordering assistance at 800-665-2882 or 312-464-5199, Monday through Friday, 8:30am - 4:45pm CT.

******Join or renew your AMA membership today---call 800-AMA-3211******

Indicate AMA Membership Status: _____Member Physician _____Nonmember Physician

Membership Type	**Standard Mail Service*** (within 10 business days)	**Express Service*** (within 5 business days)
AMA Member Physician	No charge	$6 per profile
Nonmember Physician	$26 per profile	Not available

****Prices are subject to change without advance notice.***

Credit card payment is preferred as check payments may extend processing time. Checks should be made payable to the American Medical Association, Remittance Control Area/PPS, Accounting Department, PO Box 109054, Chicago, IL 60610. Orders faxed to the AMA must include credit card information for billing purposes.

___ VISA ___ American Express ___ MasterCard Charge Amount: **$**_____

Credit Card Number _____Expiration Date: ____/____/____

Name on Credit Card: _____

Billing Address:_____

Approval Signature_____ Daytime Telephone: _____

Part 1: AMA Physician Profile Delivery Information

Please send my profile to the following state licensing or medical specialty board:

Board Name: _____

NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

_____
Physician Name (first, middle, last, suffix)

_____ ____/____/____ _____
Place of Birth Date of Birth Social Security Number

_____ _____
E-mail Address Medical Education Number (optional)

_____
Preferred Mailing Address

_____ (_____)_____-_____
City, State, Zip Code Telephone Number

The above address is my OFFICE ___ HOME ____ OTHER ___

If address is home or other, please complete this section.

_____
Primary Office Address

_____ (____)_____-_____
City State Zip Code Office Telephone Number

Part 3: Medical Education and Other Information

Medical School of Graduation _____ Year of Graduation _____

DEA Number _____ ECFMG Number _____

Residency Training

Residency Training (institution/hospital name, location, and years)

_____

_____

Hospital Admitting Privileges

Hospital Name	City/State

Group Practice Affiliation(s)

Group Practice Name	City/State

Physician Agreement

Agreement must be signed in order to process your request.
AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X_____ _____/_____/_____
Signature Date

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

REQUEST FOR PHYSICIAN PROFILE DATA

MEDICAL EXAMINING BOARD

FEES:

AOA Members - No Charge
Non-Members - $20.00

APPLICANT: PLEASE COMPLETE THIS FORM AND FORWARD TO THE AMERICAN OSTEOPATHIC ASSOCIATION AT THIS ADDRESS:

American Osteopathic Association
Physicians' Biographic Records
142 East Ontario St.
Chicago IL 60611-2864
800-621-1773, Ext. 8145
FAX: (312) 202-8206
AOA Website (www.aoa-net.org)

The **State of Wisconsin** requests a physician profile concerning the following individual:

NAME	DAYTIME PHONE NUMBER
ADDRESS	DAYTIME PHONE NUMBER
CITY, STATE AND ZIP	YEAR OF GRADUATION (from Med. Sch) DEGREE
DATE OF BIRTH	E.C.F.M.G. NUMBER
SOCIAL SECURITY NUMBER	AOA NUMBER

Physician's Signature **Date**

ATTENTION: AMERICAN OSTEOPATHIC ASSOCIATION

Please mail the response directly to the Wisconsin Medical Examining Board at the following address:

Department of Regulation & Licensing
Medical Examining Board
PO Box 8935
Madison WI 53708

#1935 (Rev. 01/03/03)
Ch. 448, Stats.

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
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Madison, WI 53703
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Website: http://www.drl.state.wi.us

DISCIPLINARY INQUIRIES REPORT

MEDICAL EXAMINING BOARD

(Not necessary if utilizing FCVS)

APPLICANT MUST COMPLETE THIS FORM AND FORWARD TO THE FEDERATION OF STATE MEDICAL BOARDS AT THIS ADDRESS:

FEDERATION OF STATE MEDICAL BOARD, INC.
FEDERATION PLACE
P.O. BOX 619850
DALLAS, TX 75261-9850

Attention: State Board Inquiries

The State of Wisconsin requests a Board Action Search concerning the following individual:

Practitioner's Name (Last, First, Middle) Degree

Date of Birth (month/day/year)

Medical School

Year of Graduation

Social Security Number

ECFMG #

Practitioner's Signature: _____

FEDERATION OF STATE MEDICAL BOARDS

The **State of Wisconsin** requests a disciplinary search concerning the above individual. **Please mail the response to the following address:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

#1445 (Rev. 03/03)
Ch. 448, Stats.

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935

FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a $6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: _____

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

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

_____ month _____ day _____ year

Social Security Number

_____

Information helps us identify your record, but is voluntary. It is not available to the public.

Ethnic/gender information is required to check criminal information records.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: _____

2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

   It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

OFFENSE	DATE	CITY/STATE

Attach additional sheet(s) if necessary.

State of Wisconsin Department of Regulation & Licensing

	YES	NO	MO/YR COMPLETED
3. Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program?	☐	☐	_____
Did you successfully complete the program?	☐	☐	_____

Please attach the certificate of completion/discharge summary.

	(Check all that apply)	YES	NO	MO/YR COMPLETED
4. Have you ever been sentenced to:	☐ Probation	☐	☐	_____
	☐ Parole	☐	☐	_____
	☐ Ordered to pay restitution	☐	☐	_____
Did you successfully complete one of the above as ordered by the court?		☐	☐	_____

If you are <u>currently</u> on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are **<u>pending</u>**. Submit a copy of the police report/criminal complaint for each of the following pending charges.

PENDING CHARGE	DATE OF ARREST	LOCATION OF ARREST (city/state)

Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

_____

_____

_____

_____

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

_____
Signature

State of _____ County of _____

Signed and sworn before me this _____ day of _____, 20 _____ by _____
(applicant's name)

_____
Signature of Notary Public

My commission (is permanent) _____ expires _____.

SEAL

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APPLICATION PACKET ADDENDUM (INTERNET)

MD and DO application packet needing to take Step 3 of USLME

For the application packet that you have just downloaded, there are additional materials needed. **The USMLE Step 3 application will be included.**

Please complete this form and fax it to the number listed above. Once the form is returned we will mail the additional items to the address you have provided. If you prefer, you can mail this form directly to the Department of Regulation and Licensing, P.O. Box 8935, Madison, WI 53708.

Please indicate on this form if you have downloaded the Wisconsin Statutes and Code Book for this profession. ☐ Yes ☐ No

PLEASE PRINT OR TYPE

_____ _____
Full Name Daytime Phone Number

_____
Street Address

_____
PO Box

_____
City, State, Zip

Thank you.

#2612 (4/03)