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.

Department of Regulation & Licensing

State of Wisconsin
(608) 266-2811
TTY# (608) 267-2416 hearing or speech
TRS# 1-800-947-3529 impaired only

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

PODIATRIST AFFILIATED CREDENTIALING BOARD

APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE AND SURGERY

Information requested is required for processing.

PLEASE TYPE OR PRINT IN INK

Last Name: _____ **First Name:** _____ **MI:** _____

Former Name(s) - (If Applicable): _____

Street Address: _____
(A Post Office Box is NOT Acceptable)

City: _____ **State:** _____ **Zip:** _____

Phone (days): (____) _____ **Date of Birth:** _____

Ethnic and gender status information is optional, and is for research and reporting to the Equal Employment Opportunity Commission.

Race:
_____ (1) White, not of Hispanic origin
_____ (2) Black, not of Hispanic origin
_____ (3) Hispanic
_____ (4) American Indian or Alaskan
_____ (5) Asian or Pacific Islander
_____ (6) Other

Sex: _____ M _____ F

School Name: _____

School Address: _____
(City) (State)

Date Diploma Granted: _____
month/day/year

Degree: _____ **Specialty:** _____

BOARD OFFICE USE ONLY
Temporary Permit Requested: _____ Yes _____ No

APPLICATION FEES Please check applicable blank: (Make check payable to the Department of Regulation and Licensing & attach to this application.)

For Receipting Use Only

_____ **PMLexis & State Law**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 15.00 Contract Exam Fee
$ 125.00 Total Fee Attached**

PLUS $ 625.00 PMLexis Fee *(Attach certified check or money order made payable to NBPME to this application)*

_____ **Endorsement of PMLexis**
$ 150.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 207.00 Total Fee Attached**

_____ **Endorsement of Old State Board & National Board Exam**
$ 150.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 207.00 Total Fee Attached**

_____ **Temporary License**
$ **10.00** Is required in addition ot the above fee *(non-refundable)*

****ORAL EXAMINATION: $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.

#575 (Rev. 10/01)
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:

Copy of professional diploma and translation if necessary.

Certificate of Professional Education (Form #1921).

Copies of malpractice suit(s).

Addendum to Application Form (Form # 2380)

Fee(s) attached to this application.

Letters from all State Boards where licensed (includes active and inactive licenses).

Wisconsin Statutes and Rules Examination Booklet and Answer Sheet.

National Examination Scores (must be sent directly to this office from National Board).

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	DATE OF GRADUATION

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

SCHOOL	DEGREE	DATE OF GRADUATION

POST-GRADUATE TRAINING AND ACTIVITIES: (Outline in chronological order all activities from the date of graduation from podiatric school to the present time. Must include professional and nonprofessional activities. All time and dates must be accounted for.)

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

I AM CREDENTIALED IN THE FOLLOWING STATES (UNLIMITED):

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN PODIATRIST AFFILIATED CREDENTIALING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, CREDENTIAL 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

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 NBPME 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.	☐	☐
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.	☐	☐

State of Wisconsin Department of Regulation & Licensing

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned podiatric medicine and surgery judgments and to learn and keep abreast of podiatric medicine and surgery developments; and
2. The ability to communicate those judgments and podiatric medicine and surgery 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 podiatric medicine and surgery 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.

14. Do you have a medical condition which in any way impairs or limits your ability to practice podiatric medicine and surgery 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 podiatric medicine and surgery 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. ☐ ☐

State of Wisconsin Department of Regulation & Licensing

TEMPORARY LICENSE REQUEST

If you are requesting temporary licensure in order to begin practicing prior to the next oral-practical examination, complete this portion.

I hereby make application for a temporary license to practice podiatric medicine and surgery in _____, Wisconsin, beginning _____, 19_____. I clearly understand that this license, if issued, will expire 60 days after the next oral-practical examination which is scheduled for _____, 19_____, providing I appear for the examination. I understand that if I do not appear at this examination, the temporary license will automatically expire on the first day of the scheduled examination.

TEMPORARY LICENSE MUST BE APPROVED BY TWO MEMBERS OF THE PODIATRIST AFFILIATED CREDENTIALING BOARD AND APPROVAL CANNOT BE REQUESTED UNLESS A COMPLETED APPLICATION AND ALL SUPPORTING DOCUMENTS ARE ON FILE IN THE BOARD OFFICE.

AFFIDAVIT OF APPLICANT

I, the above-named applicant, 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 Podiatrist Affiliated Credentialing Board or the Department of Regulation and Licensing will be cause for disciplinary action.

_____ Applicant Signature

_____ Date

Subscribed and sworn to before me this _____ day of

_____ , 20 _____

_____ Notary Public

SEAL

_____ State

My Commission Expires: _____

NOTE: This affidavit must be signed by the applicant in the presence of the notary public on the same date.

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DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

BUREAU OF HEALTH PROFESSIONS

IMPORTANT INFORMATION

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 anywhere from 30 to 60 days**, 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.

Committed to Equal Opportunity in Employment and Licensing

Department of Regulation & Licensing

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(608) 266-2811
TTY# (608) 267-2416] hearing or speech
TRS# 1-800-947-3529] impaired only

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FAX #: (608) 261-7083

PODIATRIST AFFILIATED CREDENTIALING BOARD

INFORMATION FOR LICENSURE TO PRACTICE PODIATRIC MEDICINE AND SURGERY

IMPORTANT, PLEASE READ BEFORE COMPLETING YOUR APPLICATION

Complete the enclosed "Application to Practice Podiatric Medicine and Surgery" (Form #575) so we may determine whether or not you may be eligible as a candidate for licensure. **Indicate all activities from the time of graduation to the present time.**

The board utilizes the national board examination Part I and Part II of the National Board of Podiatry Examiners and the PMLexis examination as written examinations, and accepts the recommended passing scores as determined by the National Board. Each applicant is responsible for arranging for the Part I and Part II examination with the National Board.

Effective with the December 2000 examination, the PMLexis will be administered via computer. In order to be scheduled to sit for this examination, applicants must submit a completed application for license as well as a completed application for examination. Both of these applications will need to be submitted to the Department of Regulation and Licensing along with the required fees. Please note that the rules of the Wisconsin Podiatry Board state that a completed application must be submitted at least 30 days prior to the examination administration date. In order to guarantee a seat for the examination, it is recommended that candidates submit a complete application at least 75 days prior to the administration date.

An applicant who has received passing grades in a written examination conducted by another licensing jurisdiction of the United States, may submit documentary evidence thereof. The board will review the evidence to determine whether the scope and passing grades of such examinations are equivalent to those of this state at the time of the applicant's examination. If the board finds such equivalency, the board will accept this in lieu of requiring the applicant to achieve a passing grade in the National Board Examination.

All applicants for Wisconsin licensure are required to pass an open book examination on Wisconsin statutes and rules related to the practice of podiatric medicine and surgery in this state. The passing score is 85% correct.

TEMPORARY LICENSE

If an applicant wishes to begin practice prior to the oral-practical examination, the applicant must complete the portion of the application "Temporary License Request" and submit the additional fee as required by law.

#1427 (Rev. 7/00)
Ch. 448, Stats.

Department of Regulation & Licensing

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FAX #: (608) 261-7083

PODIATRIST AFFILIATED CREDENTIALING BOARD

PODIATRIC MEDICINE AND SURGERY CERTIFICATE OF PROFESSIONAL EDUCATION

THIS FORM MUST BE COMPLETED BY YOUR PODIATRIC SCHOOL
AND RETURNED TO THE MEDICAL EXAMINING BOARD

APPLICANT - Please complete this section.

NAME (First, Middle, Maiden, Last) _____	**Social Security Number*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
ADDRESS (City, State, Zip) _____	**Date of Graduation** ___ ___ / ___ ___ / ___ ___

CERTIFYING SCHOOL - Please complete this section.

NAME OF INSTITUTION _____	**LOCATION OF INSTITUTION** _____
DEGREE AWARDED _____	**MAJOR** _____
DATE DIPLOMA GRANTED _____	

_____
Signature of Dean or Department Head

_____
Date

SCHOOL SEAL

* For use in the school locating your records.

#1921 (Rev. 2/99)
Ch. 448, Stats.

Department of Regulation & Licensing

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PODIATRIST AFFILIATED CREDENTIALING BOARD

CERTIFICATE OF POSTGRADUATE TRAINING

Information requested is required for processing.

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:

PODIATRIST'S NAME: _____

HOSPITAL NAME: _____

HOSPITAL ADDRESS: _____

HOSPITAL TELEPHONE: _____

1. In what type and level(s) of training did this podiatrist participate at your facility? Check each level in which podiatrist 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 _____				

	YES	NO
2. Was the residency accredited by Council of Podiatric Medical Education (CPME)?	☐	☐
3. Did the podiatrist complete the full training program in good standing? If no, please attach explanation on a separate sheet.	☐	☐
4. Was the podiatrist 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 podiatrist 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 podiatrist granted a leave of absence while training at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
7.	Did this individual have a record of unexcused absences during his/her attendance at this training program?	☐	☐
8.	Were any restrictions and/or special requirements placed on this podiatrist's activities that were not placed on all other residents at his/her level of training? If yes, please attach explanation on a separate sheet.	☐	☐
9.	Were any formal patient or staff complaints filed against this podiatrist? If yes, please attach explanation on a separate sheet.	☐	☐
10.	Were any incident reports filed involving the professional behavior or conduct of this podiatrist? If yes, please attach explanation on a separate sheet.	☐	☐
11.	Was this podiatrist ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
12.	Were any malpractice actions filed naming this podiatrist as a defendant that involved his/her period of training at your facility? If yes, please attach explanation on a separate sheet.	☐	☐
13.	Is there any additional information in this podiatrist'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
Podiatrist Affiliated Credentialing Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation & Licensing

State of Wisconsin **MEDICAL EXAMINING BOARD – PODIATRIST** P.O. Box 8935, Madison, WI 53708
(608) 266-2812
TDD# (608) 267-2416-hearing impaired only

AUTHORIZATION AND WAIVER
Information Requested is Required for Processing Application
BOTH FORMS MUST BE SIGNED AND NOTARIZED IN BOTH SPACES PROVIDED

I, _____ born at _____ on _____, having filed an application for a license to practice podiatric 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 podiatric 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 podiatric 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 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

Subscribed and sworn to before me this
_____ day of _____, 19____.

_____
NOTARY PUBLIC

#792 (rev. 4/91)
Ch. 448, Wis. Stats.

HP-72

Committed to Equal Opportunity in Employment and Licensing

Department of Regulation & Licensing

State of Wisconsin **MEDICAL EXAMINING BOARD – PODIATRIST** P.O. Box 8935, Madison, WI 53708
(608) 266-2812
TDD# (608) 267-2416-hearing impaired only

AUTHORIZATION AND WAIVER
Information Requested is Required for Processing Application
BOTH FORMS MUST BE SIGNED AND NOTARIZED IN BOTH SPACES PROVIDED

I, _____ born at _____ on _____, having filed an application for a license to practice podiatric 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 podiatric 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 podiatric 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 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

Subscribed and sworn to before me this
_____ day of _____, 19____.

_____
NOTARY PUBLIC

#792 (rev. 4/91)
Ch. 448, Wis. Stats.

HP-72

Committed to Equal Opportunity in Employment and Licensing

Department of Regulation & Licensing

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FAX #: (608) 267-1803

ADDENDUM TO APPLICATION

Information requested is required for processing.

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

☐☐☐ - ☐☐ - ☐☐☐☐
Social Security Number or FEIN

Type of Credential

Date of Birth

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]

INFORMATION AVAILABLE TO THE PUBLIC - NONDISCLOSURE OF CERTAIN PERSONAL INFORMATION

☐ Your name, credential number, address, status and other credentialing information are available to the public. However, you may check this box to declare that your name and address not be disclosed on any list of ten or more individuals that the department furnishes to another person.[5]

DELINQUENT STATE TAXES; DELINQUENT SUPPORT

All applications for professional credentials are checked to determine whether the applicant is liable for delinquent state taxes. Under state law, the department must deny your application if you are liable for delinquent Wisconsin taxes.[6] If you are liable for delinquent state taxes, pay the delinquent amount before the application process is completed. Retain proof that you have satisfied the tax delinquency. If you have any questions about payment of delinquent taxes, please contact your nearest Department of Revenue office or call (608) 261-6249. An application may be denied or a credential suspended if an applicant or credential holder is delinquent in paying support or fails to comply with a subpoena or warrant issued by the department of workforce development or a county child support agency related to support or paternity proceedings.[2]

#2380 (Rev. 10/00)

[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
[5] Section 440.14, Wis. Stats.
[6] Section 440.12, Wis. Stats.

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/

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.

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 Date

Signed and sworn before me this _____ day of _____, 20 _____.

_____ _____

Signature of Notary Public Date

My commission (is permanent) _____ expires _____. **SEAL**

Department of Regulation & Licensing

State of Wisconsin
(608) 266-2112
TTY# (608) 267-2416 hearing or speech
TRS# 1-800-947-3529 impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 267-1803

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. 10/00) ss. 15.04 (1) (m), 19.35, Stats.

[a] Section RL 4.06 of the Wisconsin Administrative Code

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

APPLICATION PACKET ADDENDUM (INTERNET)

Podiatrist Exam application packet

For the application packet that you have just downloaded, there are additional materials needed.

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)