Wisconsin Department of Safety and Professional Services

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

MEDICAL EXAMINING BOARD

INFORMATION FOR COMPLETING THE UNIFORM APPLICATION

The Uniform Application for Physician State Licensure (UA) is a licensure application shared by many state boards. After completing the UA, your application is securely stored and can be sent to additional boards accepting or requiring the UA without reentering the same information. You would only make updates as needed and complete the state specific requirements for each board. The UA can only be submitted via the Online License Application System (OLAS).

The Federation Credentials Verification Service (FCVS) can be used in conjunction with the UA but it is not required. FCVS is used for credential verification only and is not a licensure application. Applicants not using FCVS must provide credentials to the board for verification. Applicants using FCVS will need to complete an initial (first time) or subsequent (update) FCVS application before working on the UA. If you are using FCVS, do not complete the verification forms related to education or postgraduate training. FCVS will provide this information to the Board for you. More information is available at http://www.fsmb.org/licensure/fcvs/.

To work on your UA, select "Uniform Application (UA)" from the Sign In menu in the upper right corner of http://www.fsmb.org/, then sign in and continue as directed.

Completing the Uniform Application

Please read the following information carefully. You will be asked to provide your licensure and employment history, account for all time since medical school graduation, and provide information on medical malpractice claims. We recommend having this information on hand before you begin. Failure to submit all required information and documentation will result in processing delays.

Complete the UA as instructed online. Make special note of the information given below.

- If you indicate on the UA that you have ever used an alternate name or your name is not the same on all of your submitted documents, you must submit a certified copy of your marriage certificate, divorce decree, court order, or other document that indicates your legal name change. If you are using FCVS for credential verification, FCVS will verify your alternate name and send documentation to the Board on your behalf.

- All nine digits of your social security number must be submitted. 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 (Section 440.03, 11m, Wis. Stats.). A form for submitting a statement that you do not have a social security number is available from the Board.

  The Department may not disclose the social security number collected except to the Department of Children and Families for purposes of administering the child and spousal support program (Sections 49.22 and 440.13, Wis. Stats.), to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes (Section 440.12, Wis. Stats.), and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners per the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

- Provide both your current home address and current business/training address, otherwise an error will occur. Also, do not enter the same address for both home and work. You may use the same address for both Board Contact and Public Contact.

- If you are not using FCVS, you must contact the appropriate entity to have a certified transcript of your scores sent directly to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), you must request the transcripts from the NBME. If you are using FCVS, FCVS will provide this information to the Board for you. For exam entity contact information, see the UA FAQ at http://www.fsmb.org/licensure/uniform-application/faq.

  Note that LMCC must have been taken after January 1, 1988 and that State Board Examination reciprocity is only for exams taken prior to 1982. The state board submitting the information must include all of the subjects covered in the examination, scores received, general average, date of the examination, license number, date of issuance, status of licensure, and any information pertaining to disciplinary action. See http://www.fsmb.org/policy/contacts for a directory of state boards.

- You are not able to add or change MD or DO license information as that information comes directly into the system from the state boards. If any changes are needed (expiry date, expired or active status, etc.), email ua@fsmb.org with the correct information. Newly granted licenses may not show in the system right away, depending on the board's reporting cycle.

  List all other professional licenses you have held (nurse, EMT, etc.) in all states, territories, provinces, or foreign countries. Include temporary, courtesy, and locum tenens licenses, and instructional or training permits. All licenses must be verified, with verification including your date of birth, license number, date of issuance, and a statement regarding disciplinary actions.

  The licensure verification information resource at http://www.fsmb.org/licensure/uniform-application/ lists each board's preferred method of verification as well as verification fees. The information is subject to change at any time so we highly recommend verifying fees and requirements at the links provided.

- On the Chronology of Activities page, the Practice/Employer Name/Description field must contain either a business name or a description of your non-working time (PGT/Education, Health Issue, Military Service, Seeking Employment, or Vacation). Provide your home or school address for each non-working time. To avoid delays in processing, review this information thoroughly after importing into OLAS to ensure the information is accurate and complete.

- Clinical indicates time spent with patients. Administrative indicates time spent on other tasks, such as paperwork or research.

- On the Malpractice page, include all settlements, judgments, awards, and claims, even if no money was paid. For each case listed, provide documentation.

Review & Submit

Please review all of your entries before submitting. We strongly advise that you print or save a copy for your records. First time UA-users will be taken to a payment page for a one-time service fee of $50. This is a separate fee collected by FSMB, not by state boards, and is separate from FCVS fees.

After submitting your UA, use the application ID given in your confirmation email in the Online Licensure Application System (OLAS; https://olas.wi.gov/Home.aspx). Complete all remaining items in the OLAS. Do not resubmit your UA if any updates need to be made. Contact the Department by email or by phone to make changes in your application. The OLAS will not accept a new application ID if one has already been entered.

Complete the licensure verifications and the applicable DSPS forms located on the Board's website at http://dsps.wi.gov/LicensesPermitsRegistrations/Credentialing-Division-Home-Page/Health-Professions/Physician/Physician-Application-Forms/. Use the checklist provided at the end of these instructions to ensure you complete all required forms.

For assistance, see the Uniform Application FAQ at http://www.fsmb.org/licensure/uniform-application/faq. If your question is not listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org with your username, FCVS ID if applicable, and a detailed description. Provide a screenshot if you receive an error.

OTHER LICENSURE REQUIREMENTS

Requirements for licensure are listed at http://dsps.wi.gov/LicensesPermitsRegistrations/Credentialing-Division-Home-Page/Health-Professions/Physician/. In addition to the listed requirements for education, examinations, and postgraduate training, plus DEA number for prescribing controlled substances, please note the following:

The Data Bank (National Practitioner/Healthcare Integrity and Protection) Self Query

All applicants must request the "Practitioner Request for Information Disclosure" (Self Query) from The Data Bank. Visit http://www.npdb.hrsa.gov/pract/selfQueryBasics.jsp and click on "Start a Self-Query for an Individual." Follow the instructions to receive a self-query report. When finished, print a copy of the form for yourself and mail it directly to The Data Bank. They will send the Self Query report directly to you. Once received, send a copy to the Department. This report may be emailed to DSPSCREDMEDBD@wi.gov or faxed to 608-261-7083. For questions or assistance, call 800-767-6732 or email help@npdb.hrsa.gov.

Physician Profile Data Report from AMA or AOA

All MDs applying for licensure must request the AMA Physician Profile Data Report from the American Medical Association at https://profiles.ama-assn.org/amaprofiles. Select the option for "Physicians Only – Requests for Profiles to be sent to Licensing Boards" and follow the steps given on the AMA website. Call 800-621-8335 for assistance.

All DOs applying for licensure must request the AOA Official Osteopathic Physician Profile Report at https://www.doprofiles.org. For questions or assistance, email credentials@osteopathic.org.

Oral Interviews

The oral interview process in the State of Wisconsin was created under MED 1.06 of the Administrative Code. If you are selected to appear for an oral interview, you will be scheduled to appear before the review panel at one of the regularly scheduled Board meetings.

Panel Review: Oral Interviews

a) An applicant *may* be required to complete an oral interview 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 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 Med 1.02 shall be reviewed by an application review panel of at least two Board members designated by the Chairperson of the Board. That panel shall determine whether the applicant is eligible for a regular license without completing an oral interview. An applicant can also be required to take an oral interview under Med. 1.08 (2), if the applicant has been examined four or more times before achieving a passing grade.

Foreign Graduates

If you are not using FCVS for credential verification, provide a copy of your ECFMG certificate with "valid indefinitely" status as described on page 3. If you participated in a Fifth Pathway program, you must also provide a copy of your Fifth Pathway Certificate.

Checklists

You will have an online checklist provided by the Board to ensure you complete all requirements. The checklist provided on the following page is given to help you determine which items are needed if you are using FCVS and/or applying for certain licenses (Visiting Physician, Temporary Camp Physician, Locum Tenens, and Physicians seeking licensure via Reciprocity of MN State Board License).

Wisconsin Department of Safety and Professional Services

Uniform Application Checklist

If you are using FCVS for credential verification, FCVS will provide some of the information for you.

	Not Using FCVS	Using FCVS
Uniform Application – can only be imported to OLAS	☐	☐
Application fee (must be paid via OLAS)	☐	☐
Letters/verifications from all State Boards where licensed **including active and inactive licenses**. Refer to the Licensure Verification Information resource at http://www.fsmb.org/licensure/uniform-application/ to determine fees and process.	☐	☐
DSPS Form #571*: Authorization and Waiver	☐	☐
DSPS Form #2164*: Medical Education Verification	☐	Provided by FCVS
DSPS Form #2165*: Certificate of Postgraduate Training	☐	Provided by FCVS
DSPS Form #2167*: Hospital, Facility, and Employer Verification	☐	☐
DSPS Form #2252*: Convictions and Pending Charges **if applicable**	☐	☐
DSPS Form #3046*: Joint Commission Certified Hospital, Facility, and Employer Verification **if applicable**	☐	☐
Certified copy of marriage certificate, divorce decree, etc., **if the name on all of your credentials is not the same**	☐	☐
National Board, FLEX, State Board, USMLE, or LMCC score(s)	☐	Provided by FCVS
ECFMG certificate **if applicable**	☐	Provided by FCVS
Fifth Pathway certificate **if applicable**	☐	Provided by FCVS
Self-Query report from The Data Bank	☐	☐
Physician Profile Data Report from the American Medical Association (AMA) or American Osteopathic Association (AOA)	☐	☐
Copy of a license to practice medicine and surgery in another state or Canada and a letter of good standing **– only required for Visiting Physician**	☐	☐
Copy of current unrestricted Minnesota license **– only required for those applying for certification via Reciprocity of MN State Board License; this does not apply for individuals who hold a MN Telemedicine license**	☐	☐
Copy of a current registration card to practice medicine and surgery in another jurisdiction in the United States or Canada **– only required for Locum Tenens and Temporary Camp Physician**	☐	☐
A letter from a physician licensed to practice medicine and surgery in the State of Wisconsin requesting the applicant's services **– only required for Locum Tenens**	☐	☐
A letter requesting the applicant's services from a camp organization or other recreational facility in the State of Wisconsin **– only required for Temporary Camp Physician**	☐	☐
FSMB Board Action/Disciplinary Inquiries Report	Provided with the UA	

***** http://dsps.wi.gov/LicensesPermitsRegistrations/Credentialing-Division-Home-Page/Health-Professions/Physician/Physician-Application-Forms/

Wisconsin Department of Safety and Professional Services

BASIS FOR LICENSURE / APPLICATION FEES

☐ Administrative Physician
If you would like to apply for an Administrative Physician license, please check this box along with the appropriate method below.

☐ Endorsement of Steps 1, 2, and 3 of USMLE
$ 75.00 Initial Credential Fee

☐ Endorsement of National Boards (NBME/NBOME)
$ 75.00 Initial Credential Fee

☐ Endorsement of FLEX
$ 75.00 Initial Credential Fee

☐ Endorsement of LMCC (Taken after 1/1/78)
$ 75.00 Initial Credential Fee

☐ Resident Educational License
$ 10.00 Initial Credential Fee

☐ Reciprocity of State Board Exam taken prior to 1972
$ 141.00 Reciprocal Credential Fee

☐ Reciprocity of MN State Board License
$ 141.00 Reciprocal Initial Credential Fee

☐ Temporary Camp Physician License
$ 75.00 Initial Credential Fee

☐ Locum Tenens License
$ 141.00 Initial Credential Fee

☐ Visiting Physician
$ 141.00 Initial Credential Fee

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MEDICAL EXAMINING BOARD

AUTHORIZATION AND WAIVER

Applicant: Please complete and forward this form to all sources that verify information directly to the Wisconsin Medical Examining Board (**example: verification of hospital privileges**). Provide a copy of this completed form when submitting your application materials to DSPS.

Last Name: _____

First Name: _____

Middle Initial: _____

Former/Maiden Name(s): _____

Date of Birth: __ __ / __ __ / __ __

City/State/Country of Birth: _____

Having filed an application for a license to practice medicine and surgery in the State of Wisconsin, I 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, and 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.

Applicant Signature _____ Date __ __ / __ __ / __ __

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MEDICAL EXAMINING BOARD

MEDICAL EDUCATION VERIFICATION FORM

(Not necessary if utilizing FCVS)

APPLICANT: **Please forward this form to your medical school.**

MEDICAL SCHOOL: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant's Name: _____

Social Security #: (for school use to locate your records) ☐☐☐ - ☐☐ - ☐☐☐☐

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? Start Date: ☐☐ / ☐☐ / ☐☐ End Date: ☐☐ / ☐☐ / ☐☐		
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 Physician 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 Physician have a record of unexcused absences during his/her attendance at this medical school? **If yes, please attach explanation on a separate sheet**.	☐	☐
6.	Was this Physician 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 in Physician 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 Physician recommended for post-graduate training?	☐	☐

Printed Name of Dean: _____

Signature: _____ Date ☐☐ / ☐☐ / ☐☐

Medical School, please return directly to:

DSPS
Attn: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Or you may fax/email with facility cover sheet/letter to: (608) 261-7083 or DSPSCredMedBD@wisconsin.gov**.**

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Ch. 448, Stats.

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MEDICAL EXAMINING BOARD

CERTIFICATE OF POSTGRADUATE TRAINING

(Not necessary if utilizing FCVS)

APPLICANT: **Please forward this form to your postgraduate training program(s) for completion.**

TRAINING PROGRAM: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name: _____

Hospital/Program Name: _____

Hospital/Program Address: _____

Hospital/Program's Daytime Phone: ___ - ___ - ____

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

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

	YES	NO
2. Was the internship/residency/fellowship in the United States or Canada accredited by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), the Royal College of Physicians & Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC)?	☐	☐

Wisconsin Department of Safety and Professional Services

		YES	NO
3.	Did the Physician either complete the training at your facility in good standing, or is the Physician currently in the training program and in good standing? **If no, please attach explanation on a separate sheet**.	☐	☐
4.	Was this Physician recommended for the Board Certification Examination in this specialty?	☐	☐

If you answer Yes to questions 5-14, attach an explanation on a separate sheet.

5.	Was the Physician asked, or required, to repeat any portion of the training at your facility?	☐	☐
6.	Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility?	☐	☐
7.	Was this Physician granted a leave of absence while training at your facility?	☐	☐
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?	☐	☐
10.	Were any formal patient or staff complaints filed against this Physician?	☐	☐
11.	Were any incident reports filed involving the professional behavior or conduct of this Physician?	☐	☐
12.	Was this Physician ever subject to non-routine monitoring while at your facility?	☐	☐
13.	Were any malpractice actions filed naming this Physician as a defendant that involved his/her period of training at your facility?	☐	☐
14.	Is there any additional information in this Physician's file that would assist the Board in determining this applicant's eligibility for licensure?	☐	☐
FOR PHYSICIANS CURRENTLY COMPLETING SECOND YEAR OF TRAINING AT THIS FACILITY:		☐	☐
15.	Has the Physician completed and received credit for 12 consecutive months of training in this program and is expected to continue in the program and complete at least 24 months of post-graduate training?		

If yes, please indicate the expected completion date of the 24 months of training: ☐☐/☐☐/☐☐

Printed Name of Program Director: _____

Signature of Program Director: _____ Date ☐☐/☐☐/☐☐

Postgraduate Training Program, please return directly to:

DSPS
Attn: Medical Examining Board
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Madison, WI 53708-8935

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MEDICAL EXAMINING BOARD

HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

APPLICANT: **Please forward this form to all hospitals, facilities, and employers where you have had staff privileges, employment, or appointment during the last five (5) years.**

Hospital/Facility/Employer: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name: _____

Name of Hospital/Facility/Employer: _____

Hospital/Facility/Employer's Address: _____

Hospital/Facility/Employer's Daytime Phone: ___ - ___ - ____

Hospital/Facility/Employer, you must answer all of the following questions and provide any additional information in order for this form to be considered complete.

1. What position did this Physician hold at your facility or under your employment?

_____

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

__/__/__ to __/__/__ **NOTE: If Physician is still employed/privileged, end date should indicate "to present" or "to current."**

		YES	NO
3.	Did this Physician either leave your employment in good standing, or is currently employed and in good standing? **If no, please attach explanation on a separate sheet.**	☐	☐

If you answer Yes to questions 4-9, attach an explanation on a separate sheet.

4.	Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment?	☐	☐
5.	Was this Physician granted a leave of absence while employed by you or at your facility?	☐	☐
6.	Did this Physician have a record of unexcused absences during his/her attendance at this facility or under your employment	☐	☐
7.	Were any restrictions or special requirements placed on this Physician's activities that were not placed on all other employees/staff holding similar positions?	☐	☐
8.	Were any restrictions placed on this Physician's privileges?	☐	☐
9.	Were any formal patient or staff complaints filed against this Physician?	☐	☐

Wisconsin Department of Safety and Professional Services

If you answer Yes to questions 10-15, attach an explanation on a separate sheet.

		YES	NO
10.	Was this Physician denied hospital privileges while employed by you?	☐	☐
11.	Were any incident reports filed involving the professional conduct or behavior of this Physician?	☐	☐
12.	Was this Physician ever subject to non-routine monitoring while at your facility?	☐	☐
13.	Was this Physician involuntarily removed from a call schedule for cause?	☐	☐
14.	Was this Physician subject to non-routine quality assessment review?	☐	☐
15.	Was this Physician the subject of a negative review by a quality assurance or departmental committee?	☐	☐

Name/title of Individual Supplying Information:

Signature: _____ Date ___/___/___

Hospital/Facility/Employer, please return directly to:

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DIVISION OF PROFESSIONAL CREDENTIALING PROCESSING

INFORMATION FOR COMPLETING CONVICTIONS AND PENDING CHARGES FORM

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

Important Notice: Incomplete information will delay the processing time.

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application, application fee, and an additional $8.00 conviction review fee. If you obtained fingerprints as a requirement for your application, you do not need to submit the $8.00 fee. Please consult the "Frequently Asked Questions" on page ii for more information on completing this form.

List all felonies, misdemeanors, and other violations of federal, state, or local law, including municipal ordinances resulting only in monetary fines or forfeitures, of which you have ever been convicted, in this state or any other. This includes convictions resulting from a plea of no contest, a guilty plea, or verdict. For each conviction or violation, list the type of offense, date, and location. Violations for which you received a ticket and paid a fine must be reported. You do not need to report dismissed charges. If you have charges pending, see page 3 for a list of required documents.

For each Conviction, it is your responsibility to submit the following documents:

Note: Do not submit CCAP printouts. They do not satisfy documentation requirements and cause delays in processing.

☐ **Certified copies of the Police Report or Criminal Complaint:**
Contact the Police Station(s) for copies of Police Report(s). Contact the Court(s) for copies of Criminal Complaint(s).

☐ **Judgment of Conviction and Sentencing:**
Contact the Court(s) for Judgment(s) of Conviction.

☐ **Sentencing Verification:**
Contact the Court(s) for copies of documentation indicating that you completed the terms of your sentence, including but not limited to, documents such as a letter from the Department of Corrections stating that you completed probation, jail time, a receipt from paying a fine, etc.

☐ **Chemical Dependency Assessment(s)** (Commonly referred to as 'AODA,' submit if court-ordered.)

☐ **Personal Statement for each conviction:**
The statement must include a description of the facts that led to the conviction, including who was involved, where you were, what happened and why, the penalties imposed, and verification that you completed all sentencing requirements. If you have alcohol and/or drug related convictions or pending charges, please include a statement describing your current usage of alcohol and/or drugs.

☐ **$8.00 CIB Review Fee** (if applicable)

If you discover the required information is not available after contacting the appropriate agency/police department, and/or court, please indicate this in a personal statement and submit the personal statement to DSPS, along with any documentation that is available.

The Fair Employment Act (Wis. Stat. §§ 111.31-111.395) 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.

Wisconsin Department of Safety and Professional Services

FREQUENTLY ASKED QUESTIONS

1. If I was charged with a crime but not convicted, do I need to report that or submit any documents?

- Send in a court document stating either that the charges were dismissed or that you were acquitted. If you entered into a deferred prosecution agreement, submit a copy of the agreement and verification that you have complied with all terms and conditions of the agreement.

2. If the conviction was expunged, do I need to report or submit anything?

- If a court has expunged your conviction, you must still disclose the conviction and provide all documents required for Form # 2252. Include a court document stating that the conviction was expunged.

3. What do I do if records are no longer available due to the length of time that has passed since the conviction?

- If, after contacting the appropriate records custodian (Court, Police Department, etc.), you find that documents are not available and the conviction or ordinance violation is more than five years old, indicate that the records are no longer available for that offense in your personal statement. If the conviction was a misdemeanor or ordinance violation and within the last five years, you must include a letter from the records custodian confirming the unavailability of the records. If the conviction was a felony and within the last 10 years, you must include a letter from the records custodian confirming the unavailability of the records.

4. Do I need to report or submit anything about minor traffic violations, i.e. a speeding ticket?

- There is no need to disclose most traffic violations, unless the traffic violation involves alcohol or other drug use (including Operating While Intoxicated convictions), then they must be disclosed.

5. How can I find out if I am excluded from getting a license due to a conviction?

- Whether an applicant will or will not be issued a license based on a conviction record is determined on a case-by-case basis. Each profession is regulated by its particular statutes and rules. Please refer to the statutes and rules of the profession for which you are applying in order to determine whether your conviction records are substantially related to the practice of the profession.

6. How long does it take to review these documents?

- The time period for conviction review varies depending on a variety of factors, including whether all required information and documentation has been submitted, whether the conviction record needs to be reviewed by the board, etc.

7. What are certified court records and where do I get them?

- These are records certified as true and correct by the Office of the Clerk of Courts and may include judgment of conviction, police report/incident report/criminal complaint, court-ordered assessment report, etc. Records may be obtained from the Office of the Clerk of Courts in the county in which your case was heard or relevant police department.

8. If I was underage at the time of the offense, do I need to report or submit anything?

- Yes, report the conviction. You must submit all court documents and verification that you have complied with all sentencing requirements. Any conviction received while underage involving alcohol (including convictions for Operating While Intoxicated) or other drug use must also be disclosed.

9. What needs to be in the personal statement?

- A personal statement should describe the events that led to each offense and conviction listed on Form # 2252, along with an explanation of the penalties imposed, and verification that you completed all sentencing requirements. The statement should address the "who," "what," "when," "where," "how," and "why" of the circumstances that led to each conviction. Include any information about changes in your life that you would like to be considered, including past and current alcohol and/or drug treatment programs, whether you completed those programs, and, if not, why not.

10. Do I need to hire a lawyer?

- It is your decision as to whether you hire an attorney. If you decide you want a legal opinion from an attorney, you would need to hire a private attorney, as the legal department of DSPS does not provide legal advice to applicants.

Wisconsin Department of Safety and Professional Services

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

Ship To: 1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DIVISION OF PROFESSIONAL CREDENTIALING PROCESSING

CONVICTIONS AND PENDING CHARGES FORM

Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stat. § 440.12).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440 14).

Profession	**Application/License #**	
Last Name	**First Name**	**MI**
List All Other Names Used		
Date of Birth __ __ / __ __ / __ __ __ __	**Social Security #** __ __ __ - __ __ - __ __ __ __	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.
Email Address		
Daytime Telephone Number __ __ __ - __ __ __ - __ __ __ __		

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this form.

☐ **CIB Review Fee**
$ 8.00 Total Fee Attached (only required if you were not fingerprinted as a requirement of your application)

For Receipting Use Only

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Safety and Professional Services

FORM IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED.
FOR <u>EACH</u> CONVICTION LISTED BELOW, SUBMIT:

- Personal Statement
- Form #2252 and appropriate fee(s)
- Judgment of Conviction and Sentencing
- Sentencing Verification
- Chemical Dependency Assessment(s) (if alcohol or drug-related convictions)
- Certified copies of the Police Report or Criminal Complaint

<u>NOTE</u>: Do not submit CCAP printouts. They do not satisfy documentation requirements and cause delays in processing.

List all felonies, misdemeanors, or other violations of federal, state, or local law or municipal ordinance.
Attach additional sheet(s) if necessary.

<u>CONVICTION</u>	**<u>DATE OF CONVICTION</u>**	**<u>LOCATION (City/State)</u>**
	__/__/__	
	__/__/__	
	__/__/__	
	__/__/__	
	__/__/__	
	__/__/__	

<u>YOU MUST ANSWER THE FOLLOWING QUESTIONS</u> (Attach additional sheet(s) if necessary)

1.	Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program? **If yes, did you successfully complete the program? If so, attach a certificate of completion/discharge summary**. **If you did <u>not</u> complete the program, attach a personal statement explaining why.**	☐ Yes ☐ No ☐ Yes ☐ No
2.	Have you ever been placed on probation? **If yes, did you successfully complete the probation?** **If you are currently on probation, you must request your probation officer to send a letter describing your current probation requirements and your compliance with supervision.**	☐ Yes ☐ No ☐ Yes ☐ No
3.	Have you ever been placed on parole? **If yes, did you successfully complete parole?** **If you are currently on parole, you must request your parole officer to send a letter describing your current parole requirements and your compliance with supervision.**	☐ Yes ☐ No ☐ Yes ☐ No
4.	Have you ever been ordered to pay restitution? **If yes, did you successfully pay the restitution?**	☐ Yes ☐ No ☐ Yes ☐ No

Wisconsin Department of Safety and Professional Services

FORM IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED.
FOR EACH PENDING CHARGE LISTED BELOW, SUBMIT:

- Personal Statement
- Form #2252 and appropriate fee(s)
- Certified copies of the Police Report or Criminal Complaint

NOTE: Do not submit CCAP printouts. They do not satisfy documentation requirements and cause delays in processing.

List all pending felonies, misdemeanors, or other violations of federal, state, or local law or municipal ordinance.
Attach additional sheet(s) if necessary.

PENDING CHARGE	DATE OF ARREST	LOCATION (City/State)
	__/__/__	
	__/__/__	
	__/__/__	
	__/__/__	
	__/__/__	
	__/__/__	

PLEASE TAKE NOTICE: IT IS YOUR RESPONSIBILITY TO SUBMIT ALL REQUIRED PAPERWORK FOR PROCESSING. CCAP PRINTOUTS DO NOT SATISFY DOCUMENTATION REQUIREMENTS AND CAUSE DELAYS IN PROCESSING.

Wisconsin Department of Safety and Professional Services

PERSONAL STATEMENT FOR EACH CONVICTION AND/OR PENDING CHARGE:

(Attach additional sheet(s) if necessary.)

Provide a personal statement for each conviction and/or pending charge. In each personal statement, describe the facts that led to each offense (i.e. who was involved, where you were, what happened, and why), penalties imposed, and verification that you completed all sentencing requirements.

Example of an Adequate Personal Statement: "In 2011, I was convicted of an OWI 1st. I was out with friends for a birthday party. I drank too much at the bar and made the poor decision to drive myself home. On the way home, I was pulled over for speeding. I failed the field sobriety test and blew a ".10." I was ticketed, paid a fine, and had my driver's license was suspended. I was also sentenced to do an alcohol and drug (AODA) assessment and attend treatment classes. Attached to this statement are copies of the police report from my arrest, a copy of the judgment of conviction, my AODA assessment, and records showing that I successfully completed alcohol counseling and treatment courses." If you have alcohol and/or drug related convictions or pending charges, please include a statement a describing your current usage of alcohol and/or drugs.

CONVICTION(S):

PENDING CHARGE(S):

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

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.

Signature: _____ Date: __ __ / __ __ / __ __ __ __

Wisconsin Department of Safety and Professional Services

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

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

JOINT COMMISSION CERTIFIED HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

The **State of Wisconsin** requests Joint Commission Certified employers to complete this form for all hospitals, facilities, and where the below physician currently has or previously held staff privileges, or employment during the last five (5) years. **You must answer all of the following questions and provide any additional information in order for this form to be considered complete.**

PHYSICIAN'S NAME: _____

NAME/LOCATION OF FACILITIES: Please attach a complete list of all facilities where the above physician has had employment or staff privileges under your employment.

JOINT COMMISSION CERTIFIED EMPLOYER NAME: _____

JOINT COMMISSION CERTIFIED EMPLOYER ADDRESS:

_____

JOINT COMMISSION CERTIFIED EMPLOYER TELEPHONE #: ___ - ___ - ____

JOINT COMMISSION CERTIFIED EMPLOYER ORGANIZATION NUMBER: Submit your number in the spaces below.

JOINT COMMISSION CERTIFIED EMPLOYER EMAIL ADDRESS: Submit your email address in the spaces below.

		YES	NO
1.	Has your entity received Joint Commission Certified certification?	☐	☐
2.	What position does the physician hold under your employment? _____		
3.	List the physician's dates of employment or staff privileges under your employment: __/__/__ to __/__/__		
4.	Did the physician either leave your employment in good standing or is currently employed and in good standing? **If no, please provide explanation on a separate sheet and attach to this form**.	☐	☐
5.	Was the physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment**? If yes, please provide explanation on a separate sheet and attach to this form.**	☐	☐
6.	Was the physician granted a leave of absence while employed at any of your facilities or under your employment? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐	☐

Wisconsin Department of Safety and Professional Services

		YES	NO
7.	Did this individual have a record of unexcused absences during his/her attendance at any of your facilities or under your employment? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐	☐
8.	Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees or staff holding similar positions? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐	☐
9.	Were any restrictions placed on this physician's privileges? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐	☐
10.	Were any formal patient or staff complaints filed against this physician**? If yes, please provide explanation on a separate sheet and attach to this form**.	☐	☐
11.	Was the physician denied hospital privileges while employed by you? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐	☐
12.	Were any incident reports filed involving the professional conduct or behavior of the physician**? If yes, please provide explanation on a separate sheet and attach to this form**.	☐	☐
13.	Was the physician ever subject to non-routine monitoring while at your facility? **If yes, please attach explanation on a separate sheet and attach to this form**.	☐	☐
14.	Was the physician involuntarily removed from a call schedule for cause**? If yes, please provide explanation on a separate sheet and attach to this form**.	☐	☐
15.	Was the physician subject to non-routine quality assessment review? **If yes, please provide explanation on a separate sheet and attach to this form**.	☐	☐
16.	Was the physician the subject of a negative review by a quality assurance or departmental committee**? If yes, please provide explanation on a separate sheet and attach to this form**.	☐	☐

PRINT NAME AND TITLE OF JOINT COMMISSION CERTIFIED EMPLOYER/OFFICIAL SUPPLYING INFORMATION:

SIGNATURE OF JOINT COMMISSION CERTIFIED EMPLOYER/OFFICIAL SUPPLYING INFORMATION:

DATE FORM WAS COMPLETED**:** ☐☐/☐☐/☐☐

JOINT COMMISSION CERTIFIED EMPLOYER, RETURN THIS FORM DIRECTLY TO:

DSPS
ATTN: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Or you may also fax /email with facility cover sheet /letter to: (608) 261-7083 or DSPSCredMedBD@wisconsin.gov.