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**MEDICAL EXAMINING BOARD**  
**Room 121A, 1400 East Washington Avenue, Madison**  
**Contact: Tom Ryan (608) 266-2112**  
**May 20, 2015**

*The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.*

**AGENDA**

**8:00 A.M.**

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

- A) Adoption of Agenda (1-5)**
- B) Minutes of April 15, 2015 – Review and Approval (6-13)**
- C) 8:00 A.M - APPEARANCE – DS/PS Attorney Yolanda McGowan – Presentation on Petition for Summary Suspension and Designation of Hearing Official (14-31)**
  - 1) 15 MED 004 –James B. Lisowski, M.D.
- D) Administrative Updates**
  - 1) Department and Staff Updates
  - 2) Appointments/Reappointments/Confirmations
  - 3) Election of Vice Chair and Liaison/Panel Appointments (Tentative) **(32-33)**
  - 4) Wis. Stat. s 15.085 (3)(b) – Affiliated Credentialing Boards’ Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest
  - 5) Informational Items
- E) APPEARANCE – DS/PS Staff: Jamie Adams - Division of Professional Credential Processing Update (34)**
- F) Federation of State Medical Boards (FSMB) Matters**
  - 1) Report from FSMB Annual Meeting **(35)**
    - a) Actions by the FSMB House of Delegates – April 25, 2015 **(36-39)**
- G) DEA National Heroin Threat Assessment Summary – Discussion (40-52)**
- H) NC Dental Board v. FTC Decision – Board Review with Legal Counsel (53)**

**I) Legislative/Administrative Rule Matters**

- 1) Legislative Report and Final Rule Draft for Med 3, 5, 23 Relating to Physician Licensure **(54-72)**
- 2) Update on Med 13 (CR 14-033) Relating to Continuing Education Audits and Med 18 (CR14-040) Relating to Physicians and Informed Consent **(73-86)**
- 3) Update on Pending and Possible Rule Projects
- 4) LRB-1138/1 Relating to Ratification of the Interstate Medical Licensure Compact **(87-124)**

J) Speaking Engagement(s), Travel, or Public Relation Request(s)

K) Screening Panel Report

L) Informational Items

**M) Items Added After Preparation of Agenda**

- 1) Introductions, Announcements and Recognition
- 2) Administrative Updates
- 3) Education and Examination Matters
- 4) Credentialing Matters
- 5) Practice Matters
- 6) Legislation/Administrative Rule Matters
- 7) Liaison Report(s)
- 8) Informational Item(s)
- 9) Disciplinary Matters
- 10) Presentations of Petition(s) for Summary Suspension
- 11) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
- 12) Presentation of Proposed Decisions
- 13) Presentation of Interim Order(s)
- 14) Petitions for Re-Hearing
- 15) Petitions for Assessments
- 16) Petitions to Vacate Order(s)
- 17) Petitions for Designation of Hearing Examiner
- 18) Requests for Disciplinary Proceeding Presentations
- 19) Motions
- 20) Petitions
- 21) Appearances from Requests Received or Renewed
- 22) Speaking Engagement(s), Travel, or Public Relation Request(s), and Reports

N) Public Comments

**CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).**

- O) Review of Administrative Warnings**
- 1) **9:45 A.M. – APPEARANCE – C.T. (WARN00000302)(DLSC case number 14 MED 138) (125-128)**
  - 2) **10:00 A.M. – APPEARANCE – D.R.T. (WARN00000256)(DLSC case number 14 MED 279) (129-135)**
  - 3) 14 MED 268 – J.N.G. **(136-137)**
  - 4) 14 MED 370 – P.V.K. **(138-140)**
  - 5) 14 MED 446 – C.L. **(141-142)**
- P) Monitoring Matters (143-217)**
- 1) **10:10 A.M. - APPEARANCE - Stephen A Haughey, M.D. – Requesting to be Allowed to Work in a Setting Where he has Access to Controlled Substances (146-172)**
  - 2) Ronald Rubin, M.D. – Requesting to be Allowed to Provide Patient Care **(173-217)**
- Q) Deliberation on Petition for Summary Suspension and Designation of Hearing Official (218-235)**
- 1) 15 MED 004 – James B. Lisowski, M.D.
- R) Complaint(s) for Determination of Probable Cause**
- 1) 14 MED 212 – Scott A. Schildt, M.D. **(236-239)**
  - 2) 15 MED 004 – James B. Lisowski, M.D. **(240-242)**
- S) Deliberation on Proposed Stipulations, Final Decisions and Orders by the Division of Legal Services and Compliance (DLSC)**
- 1) Edison P. McDaniels, M.D. – 14 MED 280 **(243-248)**
  - 2) Malik S. Ali, M.D. – 14 MED 377 **(249-254)**
  - 3) Sarah E. Ahrens, M.D. – 14 MED 390 **(255-260)**
  - 4) Chandralekha Bommakanti, M.D. – 14 MED 393 **(261-266)**
  - 5) Alfred J. Coron, M.D. – 14 MED 404 **(267-272)**
  - 6) Robert F. Douglas, M.D. – 14 MED 410 **(273-279)**
  - 7) John S. Harris, M.D. – 14 MED 418 **(280-285)**
  - 8) Graciela Hernandez, M.D. – 14 MED 422 **(286-291)**
  - 9) Christopher M. Huiras, M.D. – 14 MED 430 **(292-297)**
  - 10) Timothy A. Johnson, M.D. – 14 MED 432 **(298-303)**
  - 11) Sidney H. Kohler, M.D. – 14 MED 442 **(304-309)**
  - 12) Luz S. Moreno, M.D. – 14 MED 451 **(310-315)**
  - 13) George A. Munkwitz, M.D. – 14 MED 452 **(316-321)**
  - 14) David R. Nahin, M.D. – 14 MED 453 **(322-328)**
  - 15) Robert K. Ortwein, M.D. – 14 MED 456 **(329-334)**
  - 16) Andrew M. Owskiak, M.D. – 14 MED 458 **(335-340)**
  - 17) Steven J. Price, M.D. – 14 MED 463 **(341-346)**
  - 18) Tracy S. Reichmuth, M.D. – 14 MED 467 **(347-352)**
  - 19) Marcia J. Richards, M.D. – 14 MED 469 **(353-359)**
  - 20) David E. Shapiro, M.D. – 14 MED 481 **(360-366)**
  - 21) Bedriye Y. Tombuloglu, M.D. – 14 MED 489 **(367-372)**
  - 22) Jeffrey W. Wilson, M.D. – 14 MED 493 **(373-378)**
  - 23) Robert Kolb, D.O. – 14 MED 498 **(379-384)**

- 24) Gary T. Prohaska, M.D. – 14 MED 593 **(385-389)**
- 25) Amit Agarwal, M.D. – 15 MED 003 **(390-395)**
- 26) Mitchell R. Weisberg, M.D. – 15 MED 017 **(396-401)**
- 27) Jon E. Kelly, M.D. – 15 MED 116 **(402-413)**

**T) Deliberation of Order fixing Costs in the Matter of Disciplinary Proceedings against:**

- 1) Zulfiqar Ali, M.D. (ORDER0003813)(DLSC case number 14 MED 298) **(414-421)**
- 2) Nanette Liegeois, M.D. (ORDER0003604)(DLSC case number 14 MED 581) **(422-436)**  
Department's Brief and Respondent's Objections to Order Fixing Costs
- 3) Angelina Montemurro, M.D. (ORDER0002139)(DLSC case number 12 MED 288) **(437-442)**
- 4) Linda Rogow, M.D. (ORDER0003411)(DLSC case number 14 MED 033) **(443-450)**

**U) Waiver of the 12 Months of ACGME Approved Post-Graduate Training Based on Education and Training**

- 1) Bronwen Shaw, M.D. **(451-488)**

**V) Waiver of the 24 Months of ACGME Approved Post-Graduate Training Based on Education and Training**

- 1) Jean Kuriakose, M.D. **(489-563)**

**W) Correspondence Following Closing in Case 14 MED 227 (564-585)**

**X) Case Closing(s)**

- 1) 13 MED 154 **(586-590)**
- 2) 14 MED 424 **(591-592)**
- 3) 14 MED 443 **(593-594)**
- 4) 14 MED 455 **(595-602)**
- 5) 14 MED 531 **(603-605)**
- 6) 14 MED 546 **(606-611)**
- 7) 14 MED 567 **(612-617)**
- 8) 14 MED 591 **(618-620)**
- 9) 14 MED 609 **(621-623)**
- 10) 15 MED 077 **(624-626)**
- 11) 15 MED 085 **(627-629)**

**Y) Case Status Report (630-638)**

**Z) Deliberation of Items Added After Preparation of the Agenda**

- 1) Education and Examination Matters
- 2) Credentialing Matters
- 3) Disciplinary Matters
- 4) Monitoring Matters
- 5) Professional Assistance Procedure (PAP) Matters
- 6) Petition(s) for Summary Suspensions
- 7) Proposed Stipulations, Final Decisions and Orders
- 8) Administrative Warnings
- 9) Proposed Decisions
- 10) Matters Relating to Costs

- 11) Complaints
- 12) Case Closings
- 13) Case Status Report
- 14) Petition(s) for Extension of Time
- 15) Proposed Interim Orders
- 16) Petitions for Assessments and Evaluations
- 17) Petitions to Vacate Orders
- 18) Remedial Education Cases
- 19) Motions
- 20) Petitions for Re-Hearing
- 21) Appearances from Requests Received or Renewed

**AA) Consulting with Legal Counsel**

**RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

**BB) Open Session Items Noticed Above not Completed in the Initial Open Session**

**CC) Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate**

**DD) Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates**

**ADJOURNMENT**

**ORAL INTERVIEW OF CANDIDATES FOR LICENSURE  
ROOM 124D/E**

**11:30 A.M., OR IMMEDIATELY FOLLOWING FULL BOARD MEETING**

**CLOSED SESSION** – Reviewing Applications and Conducting Oral Interviews of Six (6) Candidates for Licensure – Drs. Westlake, Erickson, Misra, and Yale.

**MEDICAL EXAMINING BOARD  
MEETING MINUTES  
April 15, 2015**

**PRESENT:** Mary Jo Capodice, D.O; Greg Collins; Rodney Erickson, M.D.; Suresh Misra, M.D.; Michael Phillips, M.D.; Kenneth Simons, M.D.; Timothy Swan, M.D.; Sridhar Vasudevan, M.D.; Carolyn Ogland Vukich, M.D; Timothy Westlake, M.D. (*via GoToMeeting arrived at 8:03 a.m., excused 9:00 a.m.*); Russell Yale, M.D.; Robert Zondag

**EXCUSED:** James Barr

**STAFF:** Tom Ryan, Executive Director; Taylor Thompson, Bureau Assistant; and other Department staff

**CALL TO ORDER**

Kenneth Simons, Chair, called the meeting to order at 8:00 a.m. A quorum of eleven (11) members was confirmed.

**ADOPTION OF AGENDA**

**Amendments:**

- Additional material was added to the packet pertaining to the Full Board Oral Interview of Sohail Imran Mohammad, M.D.
- An additional item was added under Monitoring Matters – Stephen Haughey

**MOTION:** Sridhar Vasudevan moved, seconded by Suresh Misra, to adopt the agenda as amended. Motion carried unanimously.

**APPROVAL OF MINUTES**

**Corrections:**

- Quorum corrected to read “eleven”
- Case closing 14 MED 540 is for both M.J.M. and A.E.U.

**MOTION:** Suresh Misra moved, seconded by Robert Zondag, to approve the minutes of March 18, 2015 as corrected. Motion carried unanimously.

**ADMINISTRATIVE UPDATES**

**LIAISON APPOINTMENTS**

**MOTION:** Sridhar Vasudevan moved, seconded by Robert Zondag, to affirm the Chair’s appointment of Timothy Swan as the travel liaison. Motion carried unanimously.

**BOARD SPRING NEWSLETTER**

**MOTION:** Carolyn Ogland Vukich moved, seconded by Russell Yale, to approve the Spring 2015 MEB Newsletter draft as published and to request distribution as soon as possible. Motion carried unanimously.

## LEGISLATIVE/ADMINISTRATIVE RULE MATTERS

### PUBLIC HEARING ON CLEARINGHOUSE RULE 15-021 RELATING TO ENTRANCE TO EXAMS

**MOTION:** Michael Phillips moved, seconded by Greg Collins, to authorize the Chair to approve the Legislative Report and Draft for Clearinghouse Rule 15-021 relating to entrance to exams for submission to the Governor's Office and Legislature. Motion carried unanimously.

### MED 13 RELATING TO CONTINUING EDUCATION AUDITS (CR 14-033)

**MOTION:** Sridhar Vasudevan moved, seconded by Michael Phillips, to approve the Adoption Order for MED 13 relating to continuing education audits. Motion carried unanimously.

### MED 18 RELATING TO PHYSICIANS AND INFORMED CONSENT (CR 14-040)

**MOTION:** Suresh Misra moved, seconded by Mary Jo Capodice, to approve the Adoption Order for MED 18 relating to physicians and informed consent. Motion carried unanimously.

### REVIEW OF OT 1, 3, 4 RELATING TO SELF-REFERRAL OF OCCUPATIONAL THERAPY SERVICES

**MOTION:** Timothy Swan moved, seconded by Robert Zondag, to invite the Chair of the Occupational Therapists Affiliated Credentialing Board to a Medical Examining Board meeting to discuss concerns of the Board. Motion carried unanimously.

### CLOSED SESSION

**MOTION:** Sridhar Vasudevan moved, seconded by Timothy Swan, to convene to Closed Session to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). The Chair read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Mary Jo Capodice – yes; Greg Collins – yes; Rodney Erickson – yes; Suresh Misra – yes; Carolyn Ogland Vukich – yes; Michael Phillips – yes; Kenneth Simons – yes; Timothy Swan – yes; Sridhar Vasudevan – yes; Russell Yale – yes; and Robert Zondag – yes. Motion carried unanimously.

The Board convened into Closed Session at 9:09 a.m.

### RECONVENE TO OPEN SESSION

**MOTION:** Sridhar Vasudevan moved, seconded by Carolyn Ogland Vukich, to reconvene in Open Session at 11:50 p.m. Motion carried unanimously.

### VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION,

**IF VOTING IS APPROPRIATE**

**MOTION:** Sridhar Vasudevan moved, seconded by Suresh Misra, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

**FULL BOARD ORAL INTERVIEW OF CANDIDATE FOR LICENSURE**

**SOHAIL IMRAN MOHAMMAD, M.D.**

**MOTION:** Michael Phillips moved, seconded by Suresh Misra, to request the applicant to authorize release(s) allowing the Medical Examining Board to obtain all records from the training file of his MedStar Franklin Square residency and the State of Maryland Department of Health and Mental Hygiene complaint file. Motion carried unanimously.

**WAIVER OF THE 12 MONTHS OF ACGME APPROVED POST-GRADUATE TRAINING  
BASED ON EDUCATION AND TRAINING**

**FNU FAIZA, M.D.**

*Dr. Simons recused himself for the deliberation and voting in the matter of FNU Faiza, M.D.*

**MOTION:** Suresh Misra moved, seconded by Rodney Erickson, to find that the training and education of FNU Faiza, M.D. is not substantially equivalent to the requirements set forth in Wis. Stat. § 448.05(2). Motion carried.

**MONITORING MATTERS**

**ELEAZAR M. KADILE – REQUESTING PERMISSION TO ENGAGE OR PARTICIPATE IN  
RESEARCH ON HUMAN SUBJECTS**

**MOTION:** Robert Zondag moved, seconded by Carolyn Ogland Vukich, to grant the request of Eleazar Kadile for permission to participate in the study presented. Motion carried.

**STEPHEN HAUGHEY – REQUESTING ACCESS TO CONTROLLED SUBSTANCES**

**MOTION:** Michael Phillips moved, seconded by Robert Zondag, to rescind the motion from March 18, 2015, regarding Stephen Haughey. Motion carried unanimously.

**MOTION:** Timothy Swan moved, seconded by Greg Collins, to deny the request of Stephen Haughey for access to controlled substances. **Reason for denial:** Insufficient time of full compliance under the terms of the order. Motion carried unanimously.

**PETITION FOR EXAMINATION IN CASE NUMBER 15 MED 069, GRACE HEITSCH, M.D.**

**MOTION:** Timothy Swan moved, seconded by Sridhar Vasudevan, to order the Respondent to complete any necessary physical, mental, or professional examinations as ordered and approved by the Board Chair, or in the event of his unavailability the highest ranking or longest serving member of the Board. Motion carried unanimously.

**DELIBERATION ON PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS BY  
THE DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC)**

**RICK L. PERKINS, M.D. – 12 MED 002**

**MOTION:** Suresh Misra moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Rick L. Perkins, M.D., DLSC case number 12 MED 002. Motion carried unanimously.

**DILIP KUMAR TANNAN, M.D. – 13 MED 091**

**MOTION:** Greg Collins moved, seconded by Sridhar Vasudevan, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Dilip Kumar Tannan, M.D., DLSC case number 13 MED 091. Motion carried unanimously.

**LOUIS S. SENO, JR., M.D. – 13 MED 433**

**MOTION:** Robert Zondag moved, seconded by Timothy Swan, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Louis S. Seno, Jr., M.D., DLSC case number 13 MED 433. Motion carried unanimously.

**MARY BURGESSER-HOWARD, M.D. – 13 MED 501**

**MOTION:** Robert Zondag moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Mary Burgessier-Howard, M.D., DLSC case number 13 MED 501. Motion carried unanimously.

**RICHARD H. STRAUSS, M.D. – 14 MED 070**

**MOTION:** Sridhar Vasudevan moved, seconded by Carolyn Ogland Vukich, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Richard H. Strauss, M.D., DLSC case number 14 MED 070. Motion carried unanimously.

**ANN E. STANGER, M.D. – 14 MED 207**

**MOTION:** Mary Jo Capodice moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Ann E. Stanger, M.D., DLSC case number 14 MED 207. Motion carried unanimously.

**JAMAL A. ZEREIK, M.D. – 14 MED 323**

**MOTION:** Suresh Misra moved, seconded by Michael Phillips, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Jamal A. Zereik, M.D., DLSC case number 14 MED 323. Motion carried unanimously.

**JILL M. HUNT, M.D. – 14 MED 324**

**MOTION:** Michael Phillips moved, seconded by Rodney Erickson, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Jill M. Hunt, M.D., DLSC case number 14 MED 324. Motion carried unanimously.

**CHRISTOPHER A. GARCES, M.D. – 14 MED 353**

**MOTION:** Rodney Erickson moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Christopher A. Garces, M.D., DLSC case number 14 MED 353. Motion carried unanimously.

**GLENN C. STOW, M.D. – 14 MED 379**

**MOTION:** Sridhar Vasudevan moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Glenn C. Stow, M.D., DLSC case number 14 MED 379. Motion carried unanimously.

**PETER A. FERGUS, M.D. – 14 MED 414**

**MOTION:** Robert Zondag moved, seconded by Russell Yale, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Peter A. Fergus, M.D., DLSC case number 14 MED 414. Motion carried unanimously.

**RICHARD J. HENDRICKS, M.D. – 14 MED 419**

**MOTION:** Russell Yale moved, seconded by Mary Jo Capodice, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Richard J. Hendricks, M.D., DLSC case number 14 MED 419. Motion carried unanimously.

**RICHARD G. RILLING, M.D. – 14 MED 486**

*Dr. Ogland Vukich recused herself for the deliberation and voting in the matter of Richard G. Rilling – 14 MED 486.*

**MOTION:** Robert Zondag moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Richard G. Rilling, M.D., DLSC case number 14 MED 486. Motion carried unanimously.

**MOTION:** Robert Zondag moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against:

1. Robert C. Hert, M.D. – 14 MED 423
2. Janeen Hudzinski, M.D. – 14 MED 428
3. Eias E. Jweied, M.D. – 14 MED 437
4. George J. Plzak, M.D. – 14 MED 460
5. Susan L. Poe, M.D. – 14 MED 462
6. Dale S. Schaper, M.D. – 14 MED 479
7. William J. Smollen, M.D. – 14 MED 482

Motion carried unanimously.

**DELIBERATION ON COMPLAINTS FOR DETERMINATION OF PROBABLE CAUSE**

**ADEGBOYEGA LAWAL, M.D. – 13 MED 310**

*Dr. Swan recused himself for the deliberation and voting in the matter of Adegboyega Lawal, M.D. – 13 MED 310.*

**MOTION:** Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to find probable cause to believe that Adegboyega Lawal, M.D., DLSC case number 13 MED 310, is guilty of unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried unanimously.

**PRESENTATION AND DELIBERATION ON ADMINISTRATIVE WARNING(S)**

**14 MED 368 – D.G.G.**

**MOTION:** Michael Phillips moved, seconded by Suresh Misra, to issue an Administrative Warning in the matter of DLSC case number 14 MED 368 (D.G.G.). Motion carried unanimously.

**MOTION:** Robert Zondag moved, seconded by Suresh Misra, to issue administrative warnings and to close the cases in the matter of case numbers:

1. 14 MED 077 (T.J.O.)
2. 14 MED 214 (M.D.E.)
3. 14 MED 407 (S.K.D.)
4. 14 MED 431 (J.F.H.)
5. 14 MED 475 (J.A.R.)
6. 14 MED 501 (M.E.N.)
7. 15 MED 035 (T.G.N.)

Motion carried unanimously.

### **CASE CLOSING(S)**

**MOTION:** Michael Phillips moved, seconded by Greg Collins, to close the following cases according to the recommendations by the Division of Legal Services and Compliance:

1. 13 MED 090 (A.H.L.) for no violation (NV)
2. 13 MED 090 (R.S.C.) for prosecutorial discretion (P3)
3. 13 MED 157 (B.W.) for no violation (NV)
4. 13 MED 193 (T.M.M.) for no violation (NV)
5. 13 MED 341 (D.C.) for no violation (NV)
6. 13 MED 468 (J.P.) for insufficient evidence (IE)
7. 14 MED 103 (B.A.) for prosecutorial discretion (P2)
8. 14 MED 128 (M.O.) for no violation (NV)
9. 14 MED 227 (P.J.L.) for no violation (NV)
10. 14 MED 247 (M.A.B.) for no violation (NV)
11. 14 MED 349 (J.D.F.) for no violation (NV)
12. 14 MED 367 (D.J.H.) for no violation (NV)
13. 14 MED 384 (M.J.M.) for no violation (NV)
14. 14 MED 392 (N.B.) for no violation (NV)
15. 14 MED 395 (M.J.B.) for no violation (NV)
16. 14 MED 396 (L.B.T.) for no violation (NV)
17. 14 MED 426 (M.A.H.) for no violation (NV)
18. 14 MED 478 (A.M.S.) for no violation (NV)
19. 14 MED 480 (A.M.S.) for no violation (NV)
20. 14 MED 484 (K.C.S.) for lack of jurisdiction (L2)
21. 14 MED 532 (D.L.O.) for no violation (NV)

Motion carried unanimously.

### **13 MED 247 – D.J.H.**

**MOTION:** Carolyn Ogland Vukich moved, seconded by Greg Collins, to close DLSC case number 13 MED 247, against D.J.H., for prosecutorial discretion (P7). Motion carried unanimously.

### **14 MED 394 – M.W.B.**

**MOTION:** Timothy Swan moved, seconded by Robert Zondag, to close DLSC case number 14 MED 394, against M.W.B., for no violation (NV). Motion carried unanimously.

**DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES**

**MOTION:** Timothy Swan moved, seconded by Robert Zondag, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

**ADJOURNMENT**

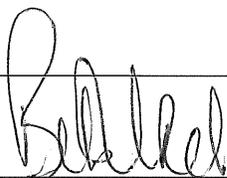
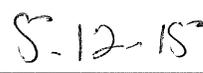
**MOTION:** Sridhar Vasudevan moved, seconded by Carolyn Ogland Vukich, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 11:51 a.m.

DRAFT

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Beth Cramton on behalf of Attorney Yolanda McGowan Division of Legal Services and Compliance		<b>2) Date When Request Submitted:</b>  May 12, 2015  Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medial Examining Board			
<b>4) Meeting Date:</b>  May 20, 2015	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Presentation of Petition for Summary Suspension in Case Number 15 MED 004, James B. Lisowski, M.D.	
<b>7) Place Item in:</b> <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input checked="" type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input checked="" type="checkbox"/> Yes ( <u>Fill out Board Appearance Request</u> ) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  Mary Jo Capodice, M.D.	
<b>10) Describe the issue and action that should be addressed:</b>  The Board must decide whether to grant the Petition for Summary Suspension. Respondent has the right to appear during open session presentation to be heard [Wis. Stat. § 448.02(4)].  The Board must decide whether there is probable cause to believe that: <ol style="list-style-type: none"> <li>1. Respondent has violated the Board's statutes and rules;</li> <li>2. It is necessary to suspend Respondent's license immediately to protect the public health safety or welfare.</li> </ol>			
<b>11)</b>		Authorization	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date			
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**BOARD APPEARANCE REQUEST FORM**

**Board Name:** Medical Examining Board

**Board Meeting Date:** May 20, 2015

**Person Submitting Agenda Request:** Beth Cramton

**Person requesting an appearance:** Attorney Yolanda McGowan

**Mailing address:** P.O. Box 7190, Madison, WI 53707-7190

**Email address:** Yolanda.McGowan@wisconsin.gov

**Telephone #:** (608) 266-3679

**Reason for Appearance:** Presentation of Petition for Summary Suspension in Case Number 15  
MED 004, James B. Lisowski, M.D.

\*\*\*\*\*

**Is the person represented by an attorney? If so, who?**

**Attorney's mailing address:**

**Attorney's e-mail address:**

**Phone Attorney:**

STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

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IN THE MATTER OF THE DISCIPLINARY :  
PROCEEDINGS AGAINST :  
: DLSC Case No. 15 MED 004  
JAMES B. LISOWSKI, M.D., :  
RESPONDENT. :

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PETITION FOR SUMMARY SUSPENSION  
Wis. Stat. § 448.02(4) and Wis. Admin. Code ch. SPS 6

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Yolanda Y. McGowan, being duly sworn on oath, upon information and belief, deposes and states, as follows:

1. I am an attorney employed by the Wisconsin Department of Safety and Professional Services, Division of Legal Services and Compliance, and in the course of my job duties have been assigned to the investigation and prosecution of case number 15 MED 004 against Respondent James B. Lisowski, M.D., for the Wisconsin Medical Examining Board.

2. My business address is 1400 East Washington Avenue, Madison, Wisconsin 53703, and my business mailing address is Post Office Box 7190, Madison, Wisconsin 53707-7190.

3. Respondent James B. Lisowski, M.D. (dob May 12, 1966), is licensed in the state of Wisconsin to practice medicine and surgery, having license number 44849-20, first issued on August 20, 2002, with registration current through October 31, 2015. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 706 Terraview Drive, Green Bay, Wisconsin 54301-1448.

4. At all times pertinent to this matter, Respondent was employed as a hospitalist practicing in Green Bay, Wisconsin.

5. In July 2014, Respondent took a leave of absence from his employer for issues related to alcohol dependency.

6. From July 31, 2014 through August 27, 2014, Respondent was admitted into a 28-day inpatient AODA program where he was diagnosed with alcohol dependency. He completed the program and was discharged with the recommendation to continue participation in a 12-Step program and outpatient therapy.

7. Respondent's return to his employment was conditioned upon his participation in the Department's Professional Assistance Procedure (PAP).

8. On September 25, 2014, Respondent applied, and on October 23, 2014, was approved for participation in PAP.

9. As a condition to participation in PAP, Respondent signed an Agreement for Participation, a copy of which is attached and incorporated as Exhibit A to the Affidavit of Michelle Schram. The Agreement for Participation included a "Statement of Facts," which the Respondent also signed, acknowledging that the facts therein are true and that they form a sufficient basis for subsequent disciplinary action.

10. Respondent subsequently returned to work.

11. During the week of January 12, 2015, Respondent's employer contacted the Department Monitor, Michelle Schram, and provided, inter alia, the following information: Since returning to work, Respondent's interaction with his physician supervisor were inappropriate – angry and disrespectful; he failed to report to work for multiple scheduled shifts without notification; he admitted to drinking, and that he had been involuntarily admitted to a psychiatric center.

12. On January 21, 2015, Respondent was discharged from PAP for lack of full compliance with the Agreement for Participation. Respondent violated the terms of the agreement by consuming alcohol and having twenty (20) missed calls,<sup>1</sup> resulting in at least one failure to provide a hair, serum or urine specimen for drug testing.

13. On February 20, 2015, the Brown County Circuit Court issued a four year domestic abuse injunction against Respondent.

14. Respondent James B. Lisowski, M.D., has committed unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(1)(a) (Oct. 2013) by violating his Agreement for Participation in PAP.

15. Respondent James B. Lisowski, M.D., has engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2)(a) (Oct. 2013) by practicing or attempting to practice under any license when unable or unwilling to do so with reasonable skill and safety.

16. Respondent James B. Lisowski, M.D., has engaged in unprofessional conduct as defined by Wis. Admin. Code § Med 10.03(2) (b) (Oct. 2013) by departing from or failing to conform to the standard of minimally competent medical practice which creates an unreasonable risk of harm to a patient or the public.

17. Based upon the above, there is probable cause to believe that Respondent is impaired such that he is unable to practice medicine and surgery with reasonable skill and safety, and that it is necessary to suspend Respondent's license immediately to protect the public health, safety or welfare.

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<sup>1</sup> "Missed calls" is the reference to a participant's failure to check in daily to see if he or she will be required to provide a specimen on that date.



STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

---

IN THE MATTER OF THE DISCIPLINARY :  
PROCEEDINGS AGAINST :  
 : DLSC Case No. 15 MED 004  
JAMES B. LISOWSKI, M.D., :  
RESPONDENT. :

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AFFIDAVIT OF MICHELLE SCHRAM

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STATE OF WISCONSIN )  
 ) SS  
COUNTY OF DANE )

MICHELLE SCHRAM, being first duly sworn, deposes and states, as follows:

1. I am the Professional Assistance Procedure Coordinator (PAP Coordinator) employed by the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), and in that position I was assigned to monitor Professional Assistance Procedure (PAP) contract participant, James B. Lisowski, M.D.

2. My business address is 1400 East Washington Avenue, Madison, Wisconsin 53703, and my business mailing address is P.O. Box 7190, Madison, Wisconsin 53707-7190.

3. Department records show that James B. Lisowski, M.D. (Respondent), born May 12, 1966, is licensed to practice medicine and surgery in the state of Wisconsin, having license number 44849-20, which was first issued on August 20, 2002 and is current through October 31, 2015.

4. Respondent's most recent address on file with the Department is 706 Terraview Drive, Green Bay, Wisconsin 54301-1448.

5. On October 23, 2014, Respondent entered the Department's PAP, pursuant to which he admitted being diagnosed with an alcohol dependency and acknowledged the need for treatment. A true and correct copy of the signed Agreement for Participation is attached as "Affidavit Exhibit A," and incorporated by reference.

6. According to the records maintained by the Division in the ordinary course of business, the following events transpired during and in relation to Respondent's participation in PAP:

- a. In January 2015, Respondent's employer reported to me that Respondent had admitted to drinking; failed to report to work for multiple scheduled shifts without notification; engaged in angry and disrespectful interactions with his physician supervisor and had been involuntarily admitted to Bellin Psychiatric Center.

Schram Affidavit  
In the matter of disciplinary proceedings against  
James B. Lisowski, M.D., Case no. 15 MED 004

- b. On February 20, 2015, according to Wisconsin Circuit Court Access records, the Brown County Circuit Court entered a four year domestic violence injunction against Respondent in case number 2015CV000045.
- c. Respondent missed twenty calls,<sup>1</sup> a violation of the participation agreement.

7. On January 21, 2015, Respondent was discharged from PAP.

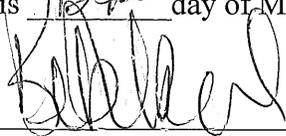
8. I notified the Respondent of his discharge from the PAP by letter dated January 21, 2015, a true and correct copy of which is attached as "Affidavit Exhibit B," and incorporated by reference. As evidenced in that letter, I recommended that Respondent continue to comply with the terms of the agreement, including drug screens.

9. As a result of Respondent's violation of the participation agreement and resultant dismissal from PAP, as part of my duties and responsibilities as PAP Coordinator, and as is customary when a PAP participant is dismissed from PAP, I referred the matter to the Division.

10. I have received no communication from Respondent since before January 15, 2015.

  
Michelle Schram

Subscribed and sworn to before me  
this 12<sup>th</sup> day of May, 2015.



Notary Public  
My Commission 3-27-2015

<sup>1</sup> "Missed calls" is the reference to a participant's failure to check in daily to see if he or she will be required to provide a specimen on that date.



PROFESSIONAL ASSISTANCE PROCEDURE  
AGREEMENT FOR PARTICIPATION

EXHIBIT

A

Date: October 22, 2014  
Participant: James B. Lisowski  
Profession: Physician  
Credential #: 44849-20

1. STATEMENT OF FACTS

I agree that the attached statement of facts is true. I also understand that the Statement of Facts may be used as evidence in a disciplinary action if I am dismissed from the procedure for failure to comply with this agreement.

2. ABSTINENCE/SOBRIETY

I agree to abstain from all personal use of alcohol.

I agree to abstain from all personal use of controlled substances as defined in Wis. Stat. § 961.01(4), except when prescribed, dispensed or administered by a practitioner for a legitimate medical condition. I agree to disclose my drug and alcohol history and the existence and nature of this Agreement and the Statement of Facts to the practitioner prior to the practitioner ordering the controlled substance. If a controlled substance is prescribed, I agree to immediately sign a release in compliance with state and federal laws authorizing the practitioner to discuss his/her treatment with, and provide copies of his/her treatment records to, the PAP Coordinator and the treatment program. I agree to have the physician report, in writing, to the treatment provider and the PAP Coordinator within three days of prescribing any medication.

I agree to abstain from all over-the-counter medications that contain mood-altering substances.

I agree to abstain from all use of over-the-counter medications or other substances that may mask the consumption of controlled substances or alcohol, create false positive screening results, or interfere with my treatment and rehabilitation.

I shall report all medications and drugs, over-the-counter or prescription, taken by me within twenty-four (24) hours of ingestion or administration and shall identify the person who prescribed, dispensed, administered or ordered said medications and drugs. Within twenty-four (24) hours of taking these medications and drugs, I will provide the PAP Coordinator a copy of the prescription/order for said medications and drugs.

3. TREATMENT PROGRAM

I acknowledge the need for treatment for chemical dependency. I agree to enroll in or remain in a Board-approved drug and alcohol treatment program at my own expense. I agree to commence

involvement in the drug and alcohol rehabilitation program within five (5) days of the date of this contract. I agree to participate in, cooperate with, and follow all treatment recommended by the drug and alcohol treatment program.

The drug and alcohol treatment program shall monitor my recovery and abstinence from drugs and alcohol. At a minimum, the program will require:

- a. Therapy: I agree to participate in individual and/or group therapy sessions at a frequency to be determined by the therapist, but no less than two (2) times per month for the first year. This requirement for therapy sessions may end upon determination by the Board Liaison or designee after receiving a written petition from the participant and a written recommendation by the therapist expressly supporting termination.
- b. AA/NA Meetings: I agree to attend Alcoholics Anonymous and/or Narcotics Anonymous or an equivalent program for recovering professionals, as recommended by my therapist, but at least two (2) times per week. Attendance at such meetings shall be verified and reported quarterly to the therapist and to the PAP Coordinator.

#### 4. SCREENING FOR DRUGS AND ALCOHOL

I agree to enroll in and participate in a drug and alcohol-monitoring program that is approved by the Department pursuant to Wis. Admin. Code § SPS 7.11 ("Approved Program"). A list of approved programs is available from the PAP Coordinator.

I agree to review all of the rules and procedures made available by the Approved Program. I understand that failure to comply with all requirements for participation in drug and alcohol monitoring established by the Approved Program may result in dismissal from the Professional Assistance Procedure and a disciplinary action may be commenced against me. The requirements shall include, but are not limited to:

- a. Contact with the Approved Program as directed on a daily basis, including vacations, weekends and holidays.
- b. Production of urine specimen at a collection site designated by the Approved Program within five (5) hours of notification of a test.

The Approved Program shall require random drug screens at a frequency of not less than 48 times per year.

If any urine, blood or hair specimen is positive or suspected positive for any controlled substances or alcohol, I agree to comply with additional tests or examinations as the treatment program, PAP Coordinator or PAP Board Liaison determine to be appropriate in order to clarify or confirm the positive or suspected positive test result.

In addition to any requirement of the Approved Program, at the request of the PAP Coordinator, PAP Board Liaison or designee, I agree to (a) submit additional urine specimens; (b) submit blood, hair, nail or breath specimens; and/or (c) furnish any specimen in a directly witnessed manner.

All confirmed positive test results shall be presumed to be valid. I understand that I must prove, by a preponderance of the evidence, an error in collection, testing or other fault in the chain of custody.

The Approved Program shall submit information and reports to the PAP Coordinator in compliance with the requirements of Wis. Admin. Code § SPS 7.11.

All expenses of enrollment and participation in the Approved Program shall be the responsibility of the participant. I shall keep any account for such payments current in all respects.

## 5. REPORTS

I agree to arrange for written quarterly work reports to be sent to the PAP Coordinator from my employer or a professional mentor pre-approved by the PAP Board Liaison if self-employed. The work reports shall evaluate my work performance and include a description of my access to controlled substances.

I agree to arrange for written quarterly reports from my therapist to be sent to the PAP Coordinator. The reports shall evaluate my attendance and progress in therapy.

I agree to submit a written quarterly report documenting my attendance at self-help groups such as AA or NA. In addition, this report will also include a statement confirming my compliance with the terms of this agreement.

All reports shall be filed with the PAP Coordinator at the following address:

Department PAP Coordinator  
Department Safety & Professional Services  
PO Box 7190  
Madison WI 53707-7190

All quarterly reports shall be timely filed and are due on or before the following dates:

February 1, 2015	May 1, 2015	August 1, 2015	November 1, 2015
February 1, 2016	May 1, 2016	August 1, 2016	November 1, 2016
February 1, 2017	May 1, 2017	August 1, 2017	November 1, 2017
February 1, 2018	May 1, 2018	August 1, 2018	November 1, 2018
February 1, 2019	May 1, 2019	August 1, 2019	November 1, 2019

## 6. CONSENTS FOR RELEASE OF INFORMATION

I agree to sign consents for release of information complying with state and federal laws authorizing release of reports to and from my treatment provider, to and from facilities conducting drug screens and to and from my employer.

## 7. CONFIDENTIALITY

I understand confidentiality will be maintained to the extent permitted or required by law; and that information relating to my participation will not be voluntarily released except pursuant to the signed consent for release of information forms.

I understand that if I am dismissed from the PAP based on violations of the terms of this agreement and the matter is referred to the Division of Legal Services and Compliance, my entire PAP file will be provided to the Division of Legal Services and Compliance.

**8. TERM FOR PARTICIPATION**

I agree to participate for a period of five (5) years from the date the agreement is signed by the PAP Coordinator. I understand that after I have complied with the agreement for the length of time indicated above, I may request, in writing, to be discharged from the Professional Assistance Procedure. I understand the decision to discharge me is at the discretion of the PAP Board Liaison. I agree to remain in compliance with this agreement until I receive written notification of discharge.

**9. PROFESSIONAL CREDENTIAL**

~~I understand that, provided I comply with all terms of the agreement, I shall retain my professional credential to practice. However, I also understand that the Division of Legal Services and Compliance may investigate any other information indicating unprofessional conduct that was not the basis of my referral to the PAP and may take disciplinary action based on that information.~~

**10. PRACTICE LIMITATIONS**

None

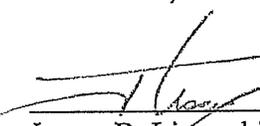
**11. VIOLATIONS**

I understand that if I violate any of the above terms, the PAP Board Liaison may dismiss me from the Professional Assistance Procedure and refer the matter to the Division of Legal Services and Compliance for disciplinary action. I understand that dismissal from the Professional Assistance Procedure does not create a right to any further hearings pursuant to Wis. Stat. §227.42. If a violation occurs and the Board Liaison allows me to remain in the Professional Assistance Procedure, I understand a revised Statement of Facts shall be obtained for violations that are substantiated and that additional conditions may be required regarding my participation in the PAP.

**12. MODIFICATION OF AGREEMENT**

I understand that I may request, in writing, modifications to this agreement after one (1) year of participation in the PAP. A written recommendation from my therapist and/or direct supervisor should support my request. I agree to make no modifications to this agreement prior to receiving written approval from the PAP Coordinator. I understand that denial of a request to modify the agreement in whole or in part does not create a right to any further hearings pursuant to Wis. Stat. §227.42.

I have read, understand and agree to the above requirements for participation.

  
\_\_\_\_\_  
James B. Lisowski, MD

10/22/14  
\_\_\_\_\_  
Date

We agree that James B. Lisowski has been approved for participation in the Professional Assistance Procedure (PAP) of the Department of Safety and Professional Services.

Mary Jo Cappadice  
PAP Board Liaison *by ms*

10/23/14  
Date

Michelle Schram  
PAP Coordinator

10/23/14  
Date

STATE OF WISCONSIN  
DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

PROFESSIONAL ASSISTANCE PROCEDURE

STATEMENT OF FACTS

1. James B. Lisowski, M.D. (DOB May 12, 1966) is licensed to practice medicine and surgery in the state of Wisconsin, pursuant to credential no. 44849-20.

2. Dr. Lisowski's most recent address on file with the Wisconsin Medical Examining Board is 706 Terraview Dr., Green Bay, WI 54301.

~~3. On September 25, 2014 Dr. Lisowski applied for the PAP. Dr. Lisowski states that he took a leave of absence from his employer Bellin Hospital at the end of July for issues related to alcohol addiction.~~

4. Dr. Lisowski was admitted to Journey Rehab Center in Salt Lake City, Utah on July 31, 2014. He was discharged from Journey Rehab Center on August 27, 2014 with a diagnosis of alcohol dependency. Dr. Lisowski returned to Green Bay with the recommendation that he continue in the 12 step program and continue in outpatient therapy.

5. Dr. Lisowski has not been reported by his employer, but in order to return to his position at Bellin Health he must enroll and participate in PAP.

6. By signing this document, Dr. Lisowski admits that the facts set forth above are true. Dr. Lisowski affirms his understanding that in the event he is terminated from the Wisconsin Professional Assistance Procedure for any reason, this Statement of Facts may be used as evidence in a disciplinary action against his license. Dr. Lisowski further agrees that the facts contained in this Statement shall be deemed as sufficient basis for subsequent disciplinary action under the requirements of Wis. Stat. § 448.02 and allowed by the Americans with Disabilities Act of 1990.

  
\_\_\_\_\_  
James B. Lisowski, M.D.  
PAP Participant

10/22/14  
\_\_\_\_\_  
Date



January 21, 2015

JAMES LISOWSKI  
706 TERRAVIEW DR  
GREEN BAY WI 54301-1448

Re: Professional Assistance Procedure (PAP) – Referral for Noncompliance

Dear Dr. Lisowski:

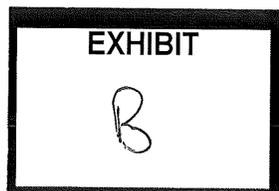
Due to substantial violations of your “Agreement for Participation”, the decision has been made to dismiss you from the PAP and refer this matter to the Division of Legal Services and Compliance for further action.

While you are no longer enrolled in the PAP, it is strongly recommended that you continue to comply with the terms of the agreement, which includes complete sobriety, drug screens, therapy sessions, AA/NA meetings, etc. Doing so will demonstrate your willingness to comply with the terms of any Board action that may result from this matter.

Please contact me with any questions concerning your PAP participation. You can expect to hear something from the Division of Legal Services and Compliance in the near future regarding possible disciplinary action.

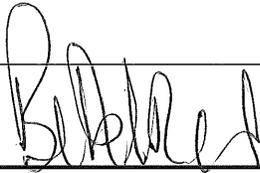
Sincerely,

Michelle Schram  
Department Monitor & PAP Coordinator  
(608) 267-7139  
[michelle.schram@wi.gov](mailto:michelle.schram@wi.gov)



**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Beth Cramton on behalf of Attorney Yolanda McGowan Division of Legal Services and Compliance		<b>2) Date When Request Submitted:</b>  May 12, 2015 Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 8 work days before the meeting for Medical Board ▪ 8 work days before the meeting for all others	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  May 20, 2015	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Presentation of Petition for Designation of Hearing Official in Case Number 15 MED 004, James B. Lisowski, M.D.	
<b>7) Place Item in:</b> <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input checked="" type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input checked="" type="checkbox"/> Yes (Fill out Board Appearance Request) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  Mary Jo Capodice, M.D.	
<b>10) Describe the issue and action that should be addressed:</b>  If the Board accepts the Petition for Summary Suspension for Respondent, then the Board, or its appointed delegates, must designate a member of the Board or an employee of the Department to preside over a hearing to show cause and issue the Order for Designation of Hearing Official.			
<b>11)</b>			Authorization  Date
Signature of person making this request		Date  S-12-15	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date			
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**BOARD APPEARANCE REQUEST FORM**

**Board Name:** Medical Examining Board

**Board Meeting Date:** May 20, 2015

**Person Submitting Agenda Request:** Beth Cramton

**Person requesting an appearance:** Attorney Yolanda McGowan

**Mailing address:** P.O. Box 7190, Madison, WI 53707-7190

**Email address:** Yolanda.McGowan@wisconsin.gov

**Telephone #:** (608) 266-3679

**Reason for Appearance:** Presentation of Petition for Designation of Hearing Official in Case  
Number 15 MED 004, James B. Lisowski, M.D.

\*\*\*\*\*

**Is the person represented by an attorney? If so, who?**

**Attorney's mailing address:**

**Attorney's e-mail address:**

**Phone Attorney:**

STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

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IN THE MATTER OF THE DISCIPLINARY :  
PROCEEDINGS AGAINST :  
 : DLSC Case No. 15 MED 004  
JAMES B. LISOWSKI, M.D., :  
RESPONDENT. :

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PETITION FOR DESIGNATION OF HEARING OFFICIAL

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Yolanda Y. McGowan, the attorney assigned to this matter, on behalf of the Department of Safety and Professional Services, Division of Legal Services and Compliance, requests the Wisconsin Medical Examining Board designate under Wis. Stat. § 227.46(1), a member of the Board, an employee of the Department or an administrative law judge employed by the Department of Administration to preside over a hearing to show cause provided for in Wis. Admin. Code § SPS 6.09. This request is made pursuant to Wis. Admin. Code §§ SPS 6.09 and 6.11(1)(a) and is based on the following:

1. The Petition for Summary Suspension, with accompanying attachments, in this matter was filed with the Medical Examining Board on May 12, 2015.

2. On May 12, 2015, Respondent was provided notice of the time and place of the presentation of the Petition for Summary Suspension by certified mail with a return receipt requested in an envelope properly stamped and addressed to Respondent at his address of record at 706 Terraview Drive, Green Bay, Wisconsin 54301-1448, and by regular mail in an envelope properly stamped and addressed to Respondent at his address of record at 706 Terraview Drive, Green Bay, Wisconsin 54301-1448.

3. The Petition for Summary Suspension will be presented to the Medical Examining Board on May 20, 2015, at which time Respondent and the prosecuting attorney may be present and will have the opportunity to be heard during the determination of probable cause by the Medical Examining Board.

4. On May 20, 2015, the Order of Summary Suspension may be issued by the Medical Examining Board.

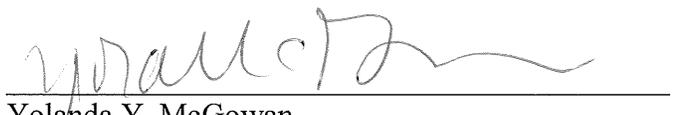
5. Pursuant to Wis. Stat. § 448.02(4)(b), Respondent is entitled to a hearing to show cause why an Order of Summary Suspension should not be continued.

6. Petitioner requests the Board designate, under Wis. Stat. § 227.46(1), a member of the Board, an employee of the Department or an administrative law judge employed by the

Petition for Designation of Hearing Official  
In the matter of disciplinary proceedings against  
James B. Lisowski, M.D., Case no. 15 MED 004

Department of Administration to preside over a hearing to show cause provided for in Wis.  
Admin. Code § SPS 6.09, in the event such hearing is requested.

Dated in Madison, Wisconsin, this 12<sup>th</sup> day of May 2015.



Yolanda Y. McGowan  
Prosecuting Attorney  
Wisconsin State Bar No. 1021905  
Department of Safety and Professional Services  
Division of Legal Services and Compliance  
P.O. Box 7190  
Madison, WI 53707-7190  
Tel. (608) 266-3679

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  <b>Nilajah Madison-Head – Bureau Assistant</b>		2) Date When Request Submitted:  <b>04/22/15</b>	
		Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections:  <b>Medical Examining Board</b>			
4) Meeting Date:  <b>05/20/15</b>	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? <b>A) Administrative Updates</b> 1) Department and Staff Updates 2) Appointments/Reappointments/Confirmations 3) Vice Chair Election and Liaison Appointments	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:  <b>N/A</b>	
10) Describe the issue and action that should be addressed:  <b>Dr. Swan will be resigning from the Medical Examining Board. The Board will hold Elections for a new Vice Chair, as well as make Liaison Appointments as needed.</b>			
11) Authorization			
<i>Nilajah Madison-Head</i>		<b>04/22/15</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

<b>2015 ELECTION RESULTS</b>	
<b>Board Chair</b>	<b>Kenneth Simons</b>
<b>Vice Chair</b>	<b>Timothy Swan</b>
<b>Secretary</b>	<b>Mary Jo Capodice</b>

<b>2015 LIAISON APPOINTMENTS</b>	
<b>Professional Assistance Procedure Liaison</b>	<b>Mary Jo Capodice</b> <i>Alternate: Michael Phillips</i>
<b>Office of Education and Exams Liaison</b>	<b>Timothy Westlake</b> <i>Alternate: Timothy Swan</i>
<b>Website Liaison</b>	<b>Timothy Swan</b> <i>Alternate: Greg Collins</i>
<b>Credentialing Liaison</b>	<b>Timothy Westlake, Mary Jo Capodice</b> <i>Alternates: Rodney Erickson, Sridhar Vasudevan</i>
<b>Legislative Liaison</b>	<b>Timothy Swan, Timothy Westlake, Kenneth Simons, Sridhar Vasudevan</b>
<b>Maintenance of Licensure Liaison</b>	<b>Rodney Erickson, Carolyn Ogland Vukich</b> <i>Alternate: Mary Jo Capodice</i>
<b>Newsletter Liaison</b>	<b>Kenneth Simons</b> <i>Alternate: Timothy Swan</i>
<b>Monitoring Liaison</b>	<b>Sridhar Vasudevan</b> <i>Alternate: Mary Jo Capodice</i>
<b>Continuing Education Liaison</b>	<b>Rodney Erickson</b> <i>Alternate: Michael Phillips</i>
<b>Rules Liaison</b>	<b>Timothy Swan</b> <i>Alternate: Russell Yale</i>
<b>Prescription Drug Monitoring Program Liaison</b>	<b>Timothy Westlake</b> <i>Alternate: Sridhar Vasudevan</i>



**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  <b>Nilajah Madison-Head – Bureau Assistant On behalf of Tom Ryan – Executive Director</b>		2) Date When Request Submitted:  <b>05/04/15</b>  <small>Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting</small>									
3) Name of Board, Committee, Council, Sections:  <b>Medical Examining Board</b>											
4) Meeting Date:  <b>05/20/15</b>	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page?  <b>Report from FSMB Annual Meeting -</b>									
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:  <b>N/A</b>									
10) Describe the issue and action that should be addressed:  funding for fsmb annual meeting <ul style="list-style-type: none"> <li>a. in additional to the executive director, chair and scholarships paid by others that are already in place...</li> <li>b. up to \$10,000 annually, with no more than \$2,500 to any one person</li> </ul> reasoning (talking points) <ul style="list-style-type: none"> <li>a. fsmb is a national leader in medical regulation</li> <li>b. cme credits available</li> <li>c. educate board members of current and future policies and standards</li> <li>d. network with peers from other states to share each others knowledge and experiences</li> </ul>											
11) <span style="float: right;">Authorization</span>  <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; border-bottom: 1px solid black;"><i>Nilajah Madison-Head</i></td> <td style="width: 40%; border-bottom: 1px solid black; text-align: right;"><b>05/04/15</b></td> </tr> <tr> <td style="border-bottom: 1px solid black;">Signature of person making this request</td> <td style="border-bottom: 1px solid black; text-align: right;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Supervisor (if required)</td> <td style="border-bottom: 1px solid black; text-align: right;">Date</td> </tr> <tr> <td colspan="2" style="border-bottom: 1px solid black;">Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date</td> </tr> </table>				<i>Nilajah Madison-Head</i>	<b>05/04/15</b>	Signature of person making this request	Date	Supervisor (if required)	Date	Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date	
<i>Nilajah Madison-Head</i>	<b>05/04/15</b>										
Signature of person making this request	Date										
Supervisor (if required)	Date										
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date											
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.											

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  <b>Nilajah Madison-Head, Bureau Assistant On behalf of Tom Ryan, Executive Director</b>		2) Date When Request Submitted:  <b>04/30/15</b>  <small>Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting</small>	
3) Name of Board, Committee, Council, Sections:  <b>Medical Examining Board</b>			
4) Meeting Date:  <b>05/20/15</b>	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  <b>A) Federation of State Medical Boards (FSMB) Matters 1) Actions by the FSMB House of Delegates – April 25, 2015</b>	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:  N/A	
10) Describe the issue and action that should be addressed:			
11) Authorization			
<i>Nilajah Madison-Head</i>		<b>04/30/15</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
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**Actions by the FSMB House of Delegates  
April 25, 2015**

1. The agenda for the April 25, 2015 House of Delegates meeting was **APPROVED**.
2. The minutes of the April 26, 2014 House of Delegates meeting were **APPROVED**.
3. The seven rules for conducting the 2015 business meeting of the House of Delegates as presented in the report of the Rules Committee were **ADOPTED**.
4. The FY 2016 budget was **ADOPTED**.

5. Elections

**Chair-elect: Arthur S. Hengerer, MD (2015-2016)**

**Treasurer: Ralph C. Loomis, MD (2015-2018)**

**Directors: Claudette E. Dalton, MD (2015-2018)  
Jerry G. Landau, JD (2015-2018)  
Gregory B. Snyder, MD (2015-2018)  
Stephen E. Heretick, JD (2015-2017)  
Mark A. Eggen, MD (2015-2016)**

**Nominating Committee:**

**Mohammed A. Arsiwala, MD (2015-2017)  
James F. Griffin, DO (2015-2017)  
Kelli M. Johnson, MBA (2015-2017)**

6. Resolution 15-1; Consistency in the Format of Electronic Medical Records (EMRs) to Enhance Readability and Usability submitted by the Texas Medical Board:

*Resolved; that the Federation of State Medical Boards (FSMB) create a committee to consider recommended guidelines on electronic medical records (EMRs) that will provide an understandable, longitudinal, patient centric view of EMR data that will allow medical professionals to care for individual patients over time and for Medical Boards to oversee the process.*

**AND**

Resolution 15-2; Task Force to Study Access by Regulatory Boards to Electronic Medical Records (EMRs) submitted by the Minnesota Board of Medical Practice:

*Resolved; that the Federation of State Medical Boards (FSMB) will establish a task force to review the format of an electronic medical record; and be it further*

*Resolved; that the FSMB task force will evaluate how information is entered into an electronic record and how information is compiled and released from an electronic format; and be it further*

*Resolved; that the FSMB task force will evaluate the feasibility of regulatory boards being allowed direct access to electronic medical records for the purpose of reviewing and downloading information necessary to a board process.*

were **combined and REFERRED TO THE BOARD OF DIRECTORS FOR STUDY AND REPORT BACK TO THE HOUSE OF DELEGATES.**

7. Resolution 15-3; Developing Model Language in Board Actions and Coordinating with ABMS on the Effects of Board Actions on Specialty Board Certification submitted by the Washington Medical Quality Assurance Commission was **REFERRED TO THE BOARD OF DIRECTORS FOR STUDY AND REPORT BACK TO THE HOUSE OF DELEGATES:**

*Resolved; that the Federation of State Medical Boards (FSMB) will establish a workgroup to develop model language in board actions and to coordinate with the American Board of Medical Specialties (ABMS) to better understand the types of actions and language that will affect board certification and to promote consistent outcomes among the state medical boards and the ABMS.*

8. **A SUBSTITUTE RESOLUTION** in lieu of Resolution 15-4; Revision of FSMB Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain submitted by the Washington Medical Quality Assurance Commission was **ADOPTED:**

*Resolved; that the Federation of State Medical Boards will establish a workgroup, comprised of state medical and osteopathic boards and other key stakeholders, such as the American Medical Association (AMA), American Osteopathic Association (AOA), specialty societies and state medical associations, to review the current science and revise the Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain.*

9. **A SUBSTITUTE RESOLUTION** in lieu of Resolution 15-5; Best Practices in the Use of Social Media by Medical and Osteopathic Boards submitted by the North Carolina Medical Board was **ADOPTED**:

*Resolved; that at its 2016 Annual Meeting, the Federation of State Medical Boards (FSMB) shall present information on current uses of social media by regulatory agencies and collect and disseminate information on best practices for regulatory agencies to follow in using social media and other forms of communication to publicize Board news and information, including public disciplinary actions.*

10. The policy document contained in BRD RPT 15-3; Elements of a State Medical and Osteopathic Board – 5<sup>th</sup> Edition was **ADOPTED**.
11. The policy document contained in BRD RPT 15-4; Essentials of a State Medical and Osteopathic Practice Act – 14<sup>th</sup> Edition was **ADOPTED**.
12. The proposed FSMB 2015-2020 Strategic Plan contained in BRD RPT 15-5; Report of the Special Committee on Strategic Positioning was **ADOPTED** and the remainder of the report filed.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  <b>Nilajah Madison-Head, Bureau Assistant On behalf of Tom Ryan, Executive Director</b>		2) Date When Request Submitted:  <b>05/13/15</b>  <small>Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting</small>	
3) Name of Board, Committee, Council, Sections:  <b>Medical Examining Board</b>			
4) Meeting Date:  <b>05/20/15</b>	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  <b>DEA National Heroin Threat Assessment Summary - Discussion</b>	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:  <b>N/A</b>	
10) Describe the issue and action that should be addressed:  <b>Board is to review the attached material and hold a discussion.</b>			
11) Authorization			
<i>Nilajah Madison-Head</i>		<b>05/13/15</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
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# (U) National Heroin Threat Assessment Summary



DEA  
INTELLIGENCE  
REPORT

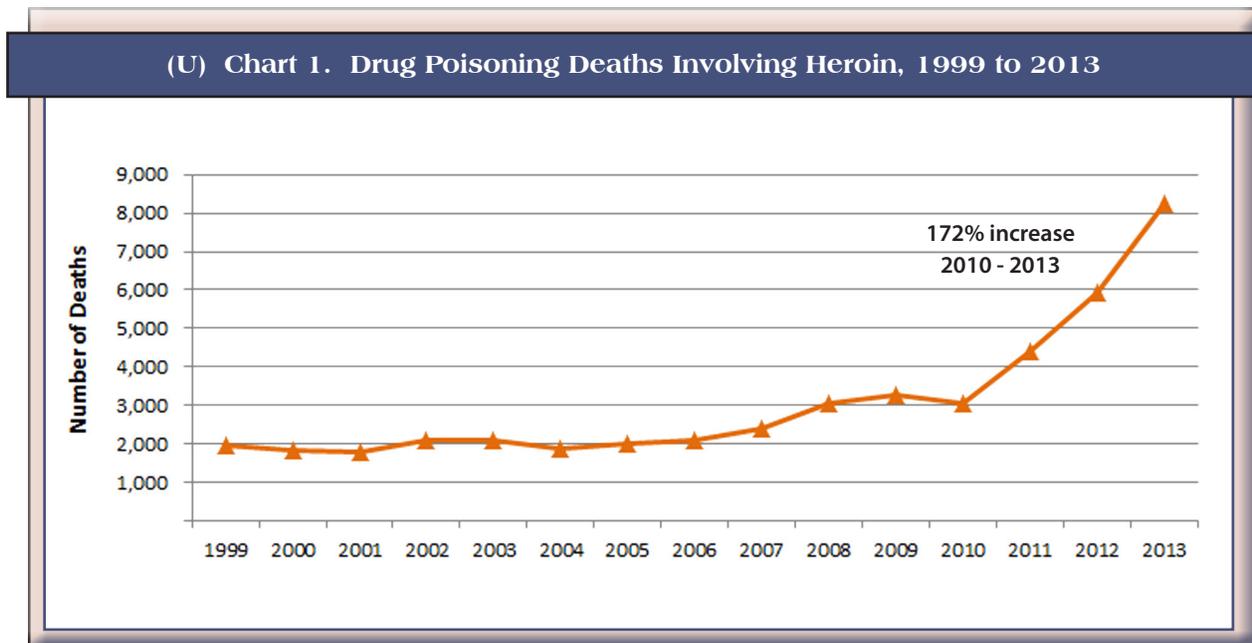
DEA-DCT-DIR-039-15

APRIL 2015



## Overview

(U) **The threat posed by heroin in the United States is serious and has increased since 2007.** Heroin is available in larger quantities, used by a larger number of people, and is causing an increasing number of overdose deaths. In 2013, 8,620 Americans died from heroin-related overdoses, nearly triple the number in 2010. (See Chart 1.) Increased demand for, and use of, heroin is being driven by both increasing availability of heroin in the U.S. market and by some controlled prescription drug (CPD) abusers using heroin. CPD abusers who begin using heroin do so chiefly because of price differences, but also because of availability, and the reformulation of OxyContin®, a commonly abused prescription opioid.



Source: National Center for Health Statistics/CDC

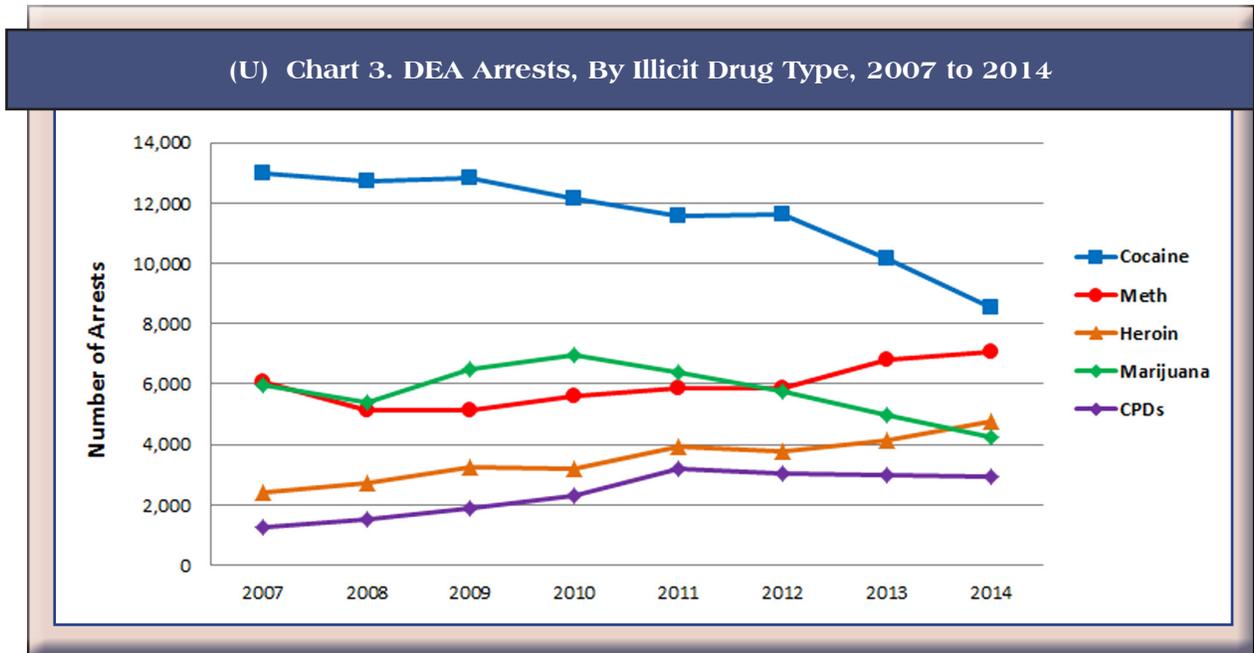
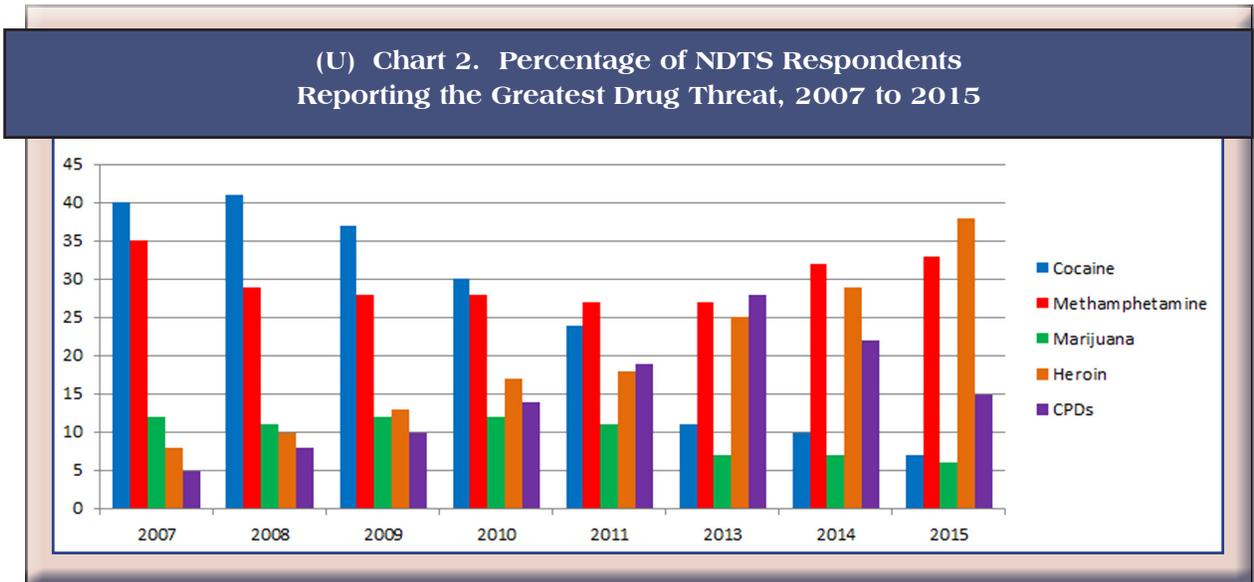
(U) **Heroin overdose deaths are increasing in many cities and counties across the United States,** particularly in the Northeast area [the Mid-Atlantic, New England, and New York/New Jersey Organized Crime Drug Enforcement Task Force (OCDETF) Regions] as well as areas of the Midwest. Many cities are reporting the increase in heroin overdose deaths is more common in the suburban areas and outlying counties surrounding the cities. Possible reasons for these increases in overdose deaths include an overall increase in heroin users; high purity batches of heroin sold in certain markets, causing users to accidentally overdose; an increase in new heroin initiates, many of whom are young and inexperienced; abusers of prescription opioids (drugs with known compositions and concentrations) initiating use of heroin, an illicitly-manufactured drug with varying purities, dosage amounts, and adulterants; and the use of highly toxic heroin adulterants such as fentanyl in certain markets. Further, heroin addicts who have stopped using heroin for a period of time (due to rehabilitation programs, incarceration, etc.) and subsequently return to using heroin are particularly susceptible to overdose, because their tolerance for the drug has decreased.

(U) **The heroin threat is particularly high in the Northeast and Midwest areas of the United States.** According to the 2015 National Drug Threat Survey<sup>a</sup> (NDTS), 38 percent of respondents reported heroin was the greatest drug threat

<sup>a</sup> (U) The National Drug Threat Survey, or NDTS, is conducted annually to solicit information from a nationally representative sample of state, local, and tribal law enforcement agencies. The recipients of the survey were queried on their perception of the drug threat in their jurisdiction relative to the availability, demand, transportation, and distribution of heroin, methamphetamine, cocaine, marijuana, CPDs, and synthetic drugs. In 2015, the survey was disseminated to 2,761 recipients. There were 1,105 respondents from across the country.

in their area; more than for any other drug. Since 2007, the percentage of NDTs respondents reporting heroin as the greatest threat has steadily grown, from 8 percent in 2007 to 38 percent in 2015. (See Chart 2.) The OCDETF regions with the largest number of respondents ranking heroin as the greatest drug threat were the Mid-Atlantic, Great Lakes, New England, and New York/New Jersey.

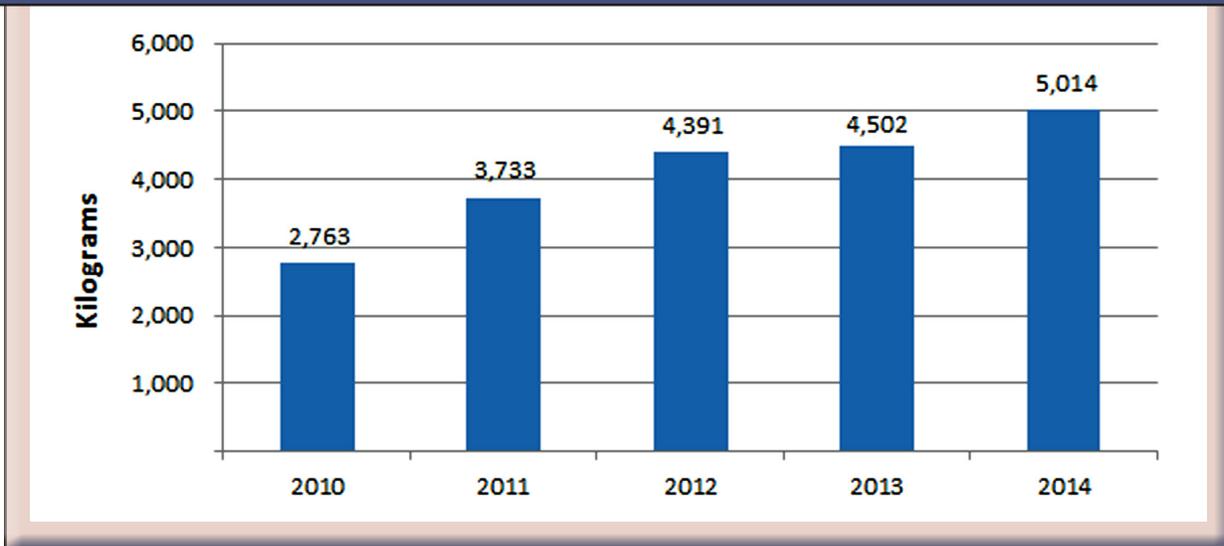
- (U) Seven<sup>b</sup> of the 21 domestic Drug Enforcement Administration (DEA) Field Divisions (FDs) ranked heroin as their number one drug threat in 2014. Another six<sup>c</sup> FDs ranked heroin as the second greatest threat to their areas. This was an increase over 2013. DEA heroin arrests nearly doubled between 2007 and 2014, and in 2014 heroin arrests surpassed marijuana arrests for the first time. (See Chart 3.)



<sup>b</sup> (U) The Chicago, Detroit, New England, New Jersey, New York, Philadelphia, and Washington Field Divisions.

<sup>c</sup> (U) The Atlanta, Caribbean, Dallas, Denver, Seattle, and St. Louis Field Divisions.

(U) Chart 4. Heroin Seizures in the United States, 2010 to 2014



Source: National Seizure System

(U) **Heroin availability is increasing in areas throughout the nation.** Availability levels are highest in the Northeast and in areas of the Midwest, according to law enforcement reporting.<sup>1</sup> Seizure data indicates a sizeable increase in heroin availability in the United States. According to National Seizure System<sup>d</sup> (NSS) data, heroin seizures in the United States increased 81 percent over five years, from 2,763 kilograms in 2010 to 5,014 kilograms in 2014. (See Chart 4.) Traffickers are also transporting heroin in larger amounts. The average size of a heroin seizure in 2010 was 0.86 kilograms; in 2014, the average heroin seizure was 1.74 kilograms. Law enforcement officials in cities across the country report seizing larger than usual quantities of heroin over the past two years.<sup>2</sup>

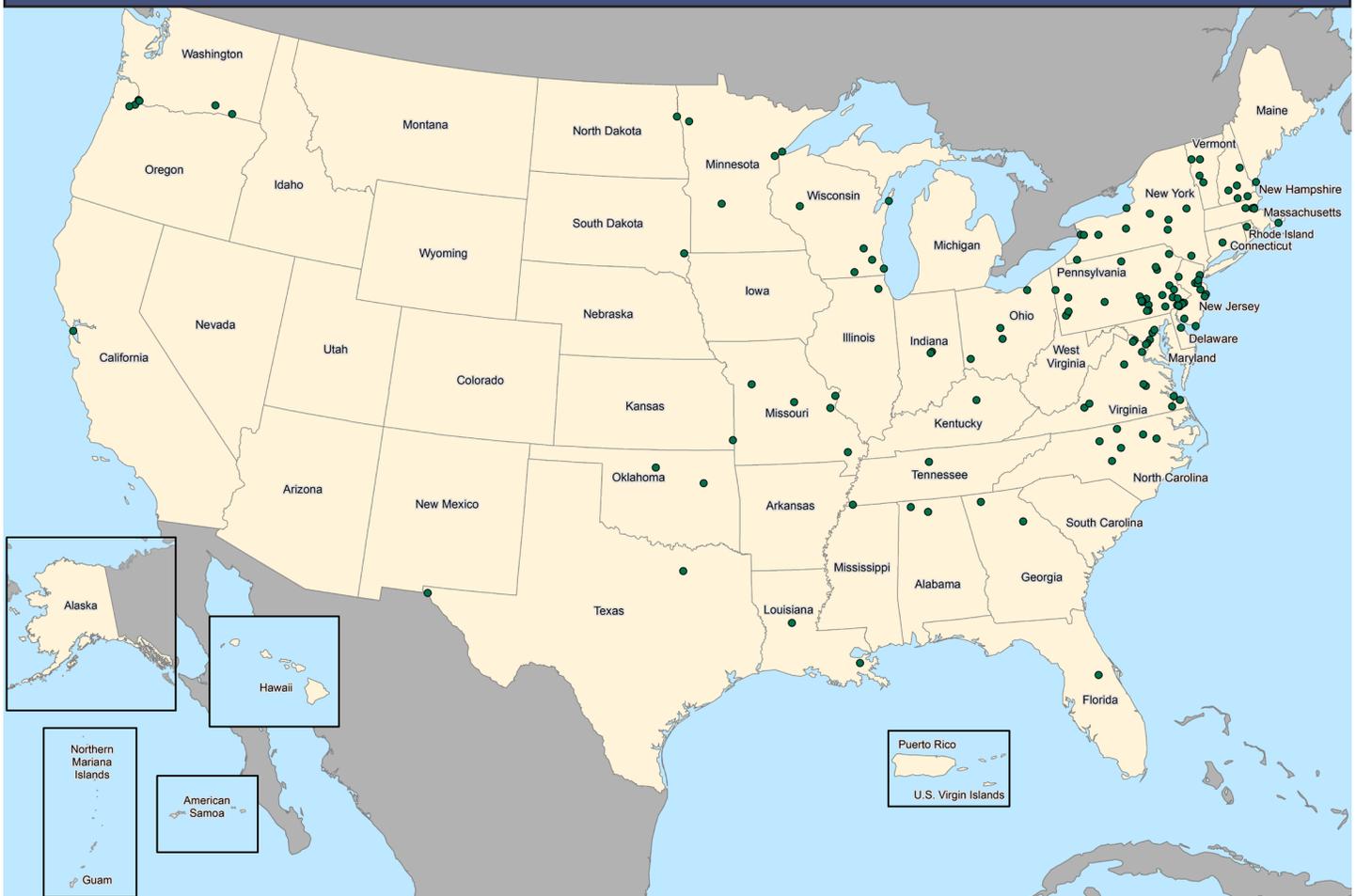
(U) **Mexican traffickers are expanding their operations to gain a larger share of eastern U.S. heroin markets.** The heroin market in the United States has been historically divided along the Mississippi River, with western markets using Mexican black tar and brown powder heroin, and eastern markets using white powder (previously Southeast and Southwest Asian, but over the past two decades almost exclusively South American) heroin. Heroin use in the United States is much more prevalent in the Northeast and Midwest areas, where white powder heroin is used. The largest, most lucrative heroin markets in the United States are the white powder markets in major eastern cities: Baltimore, Boston and its surrounding cities, Chicago, New York City and the surrounding metropolitan areas, Philadelphia, and Washington, D.C., and these are the markets where Mexican traffickers are trying to gain a larger share. Mexican organizations are now the most prominent wholesale-level heroin traffickers in the DEA Chicago, New Jersey, Philadelphia, and Washington FD Areas of Responsibility (AORs), and have greatly expanded their presence in the New York City area.<sup>3</sup>

<sup>d</sup> (U) The National Seizure System (NSS) tabulates information pertaining to drug seizures made by participating law enforcement agencies. NSS also includes data on clandestine laboratories seized in the United States by local, state, and federal law enforcement agencies. The records contained in the system are under the control and custody of DEA, and are maintained in accordance of federal laws and regulations. Seizures are reported to the El Paso Intelligence Center (EPIC) by contributing agencies and may not necessarily reflect the total seizures nationwide. Data is reported without corroboration, modification, or editing by EPIC, and accordingly, EPIC cannot guarantee the timeliness, completeness, or accuracy of the information reported herein. The data and any supporting documentation relied upon by EPIC to prepare this report are the property of the originating agency. Use of the information is limited to law enforcement agencies in connection with activities pertaining to the enforcement of criminal laws. EPIC is the central repository for these data.

(U) **The increased role of Mexican traffickers is affecting heroin trafficking patterns.** More heroin is entering the United States through the Southwest Border; consequently, the western states' roles as heroin transit areas are increasingly significant. DEA and local law enforcement reporting from several western states indicates heroin is transiting those areas in greater volumes and in larger shipment sizes. An increasing number of shipments of Mexican black tar heroin have also been seized in Northeastern markets where black tar is rarely seen, although black tar heroin seizures still comprise a very small percentage of the heroin seized in the Northeast. Finally, some Mexican trafficking organizations are moving their operations into suburban and rural areas, where they believe they can more easily conceal their activities.

(U) **In late 2013 and throughout 2014, several states reported spikes in overdose deaths due to fentanyl and its analog acetyl-fentanyl.** Fentanyl is much stronger than heroin and can cause even experienced users to overdose. There have been over 700 overdose deaths reported, and the true number is most likely higher because many coroners' offices and state crime laboratories do not test for fentanyl or its analogs unless given a specific reason to do so.<sup>4</sup> Most of the areas affected by the fentanyl overdoses are in the eastern United States, where white powder heroin is used, because fentanyl is most commonly mixed with white powder heroin or is sold disguised as white powder heroin. While pharmaceutical fentanyl (from transdermal patches or lozenges) is diverted for abuse in the United States at small levels, this latest rash of overdose deaths is largely due to clandestinely-produced fentanyl, not diverted pharmaceutical fentanyl.<sup>5</sup>

(U) **Map 1. Locations of 2014 Opioid Questionnaire Respondents Reporting an Increase in Fentanyl Incidents**



Source: 2014 Opioid Questionnaire

(U) In response to increasing overdoses caused by the use of heroin and other opioids, many law enforcement agencies are training officers to administer naloxone, a drug that can reverse the effects of opioid overdose. Law enforcement officers are often the first responders in overdose cases. Naloxone can be nasally-administered and generally has no adverse effect if administered to a person who is not suffering from opioid overdose. Some areas reported shortages of naloxone and substantial price increases in late 2014 and early 2015. The price increases will have a significant impact on state and law enforcement budgets, and shortages could have an impact on first responders' ability to assist overdose victims.

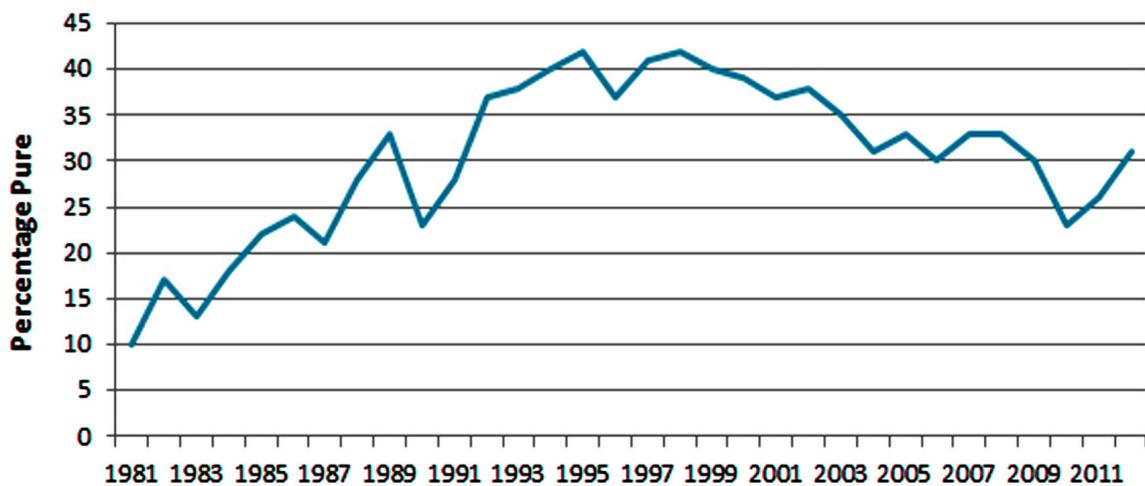
## Frequently Asked Questions

(U) How has heroin use and trafficking in the United States changed?

- (U) Heroin today is much higher in purity and lower in price

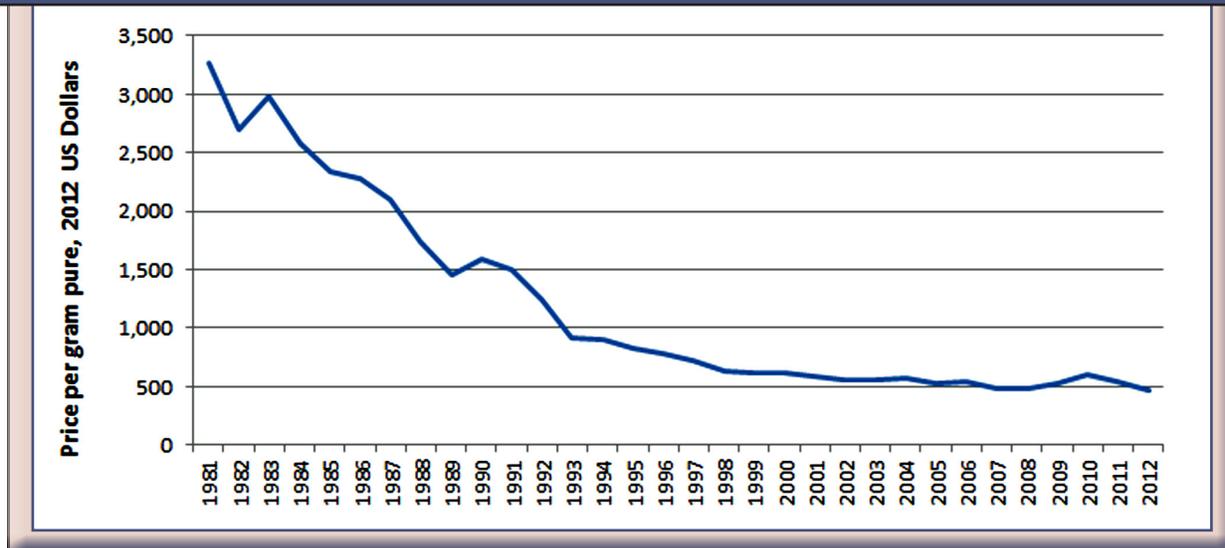
(U) Between the 1980s and 1990s, the purity of the heroin brought into the United States increased significantly. In 1981, the average retail-level purity of heroin was 10 percent. By 1999, that had increased to an average of 40 percent.<sup>6</sup> (See Chart 5.) During the same time, the price per gram pure decreased greatly. In 1981, the average price per gram of pure heroin was \$3,260 in 2012 U.S. dollars (USD) at the retail-level; by 1999, that price had decreased to \$622 (2012 USD). (See Chart 6.) Since that time, heroin prices have remained low and heroin purity levels, while fluctuating, have remained elevated.

(U) Chart 5. Retail-level Average Purity of Heroin in the United States, 1981 to 2012



Source: Institute for Defense Analyses and ONDCP

(U) Chart 6. Retail-level Average Price Per Gram Pure, for Heroin in the United States, 1981 to 2012



Source: Institute for Defense Analyses and ONDCP

- (U) Heroin is now commonly inhaled

(U) This increase in purity led to an increase in the number of heroin users in the United States. When heroin is higher in purity, it can be snorted or smoked, which broadens its appeal. Many people who would never consider injecting a drug were introduced to heroin by inhalation. In the 1990s, the drug largely lost the stigma associated with injecting, and a new population of heroin users emerged. High-purity heroin is still commonly inhaled and, according to treatment officials, remains a common method of administration by new heroin initiates.

- (U) Heroin use has spread to a broader group of users

(U) This new population of users is more diverse. Whereas in the 1970s and 1980s heroin use was largely confined to urban populations, heroin use in the 1990s and 2000s spread to users in suburban and rural areas, more affluent users, younger users, and users of a wider range of races, according to academic research.<sup>7</sup> There is no longer a typical heroin user.

- (U) Heroin in the United States is largely controlled by Mexican traffickers

(U) Mexican traffickers have taken a larger role in the U.S. heroin market, increasing their heroin production and pushing into eastern U.S. markets that for the past two decades were supplied by Colombian traffickers. This is notable because Mexican traffickers control established transportation and distribution infrastructures that allow them to reliably supply markets throughout the United States.

- (U) High levels of CPD abuse are contributing to increased heroin use

(U) In the 2000s, a very large number of people became opioid abusers by using CPDs non-medically, many after initially receiving legitimate prescriptions. Some CPD abusers throughout the country continue to use heroin when some CPDs are expensive or unavailable. After the 2010 reformulation of the commonly abused prescription opioid OxyContin®, which made it difficult to inhale or inject, some people who abused OxyContin® migrated to heroin for access to a potent injectable drug. This phenomenon is contributing to the increase in heroin use in the United States.

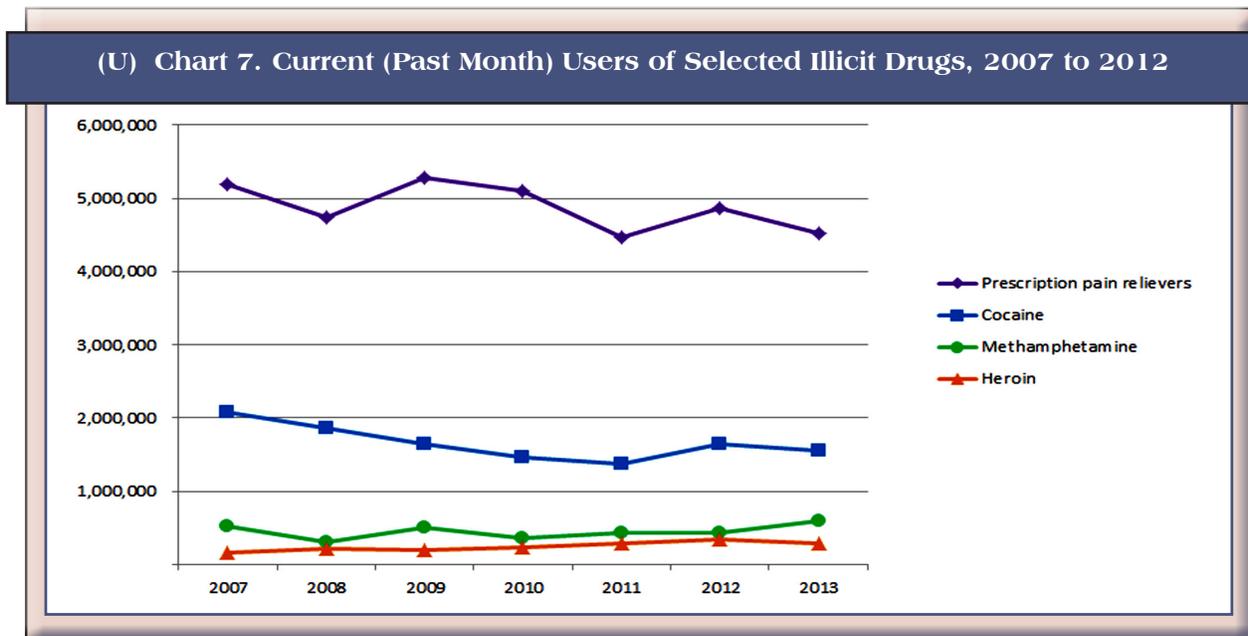
(U) How does heroin compare with other drugs of abuse in the United States?

- (U) Heroin has a smaller user population than other major illicit drugs, but, unlike other drugs, that population is growing aggressively

(U) The U.S. heroin user population is slightly smaller than the estimated methamphetamine user population and significantly smaller than the population reporting current use of marijuana, prescription pain relievers, or cocaine. (See Chart 7.) However, the heroin user population is increasing in size at a much faster rate than any other drug of abuse. The number of people reporting current heroin use nearly doubled between 2007 (161,000) and 2013 (289,000), according to the Substance Abuse and Mental Health Services Administration (SAMHSA) annual National Survey on Drug Use and Health (NSDUH).<sup>8</sup>

- (U) Heroin is far more deadly to its user population than other drugs

(U) Heroin, while used by a smaller number of people than other major drugs, is much more deadly to its users. The population that currently uses prescription pain relievers non-medically was approximately 15 times the size of the heroin user population in 2013; however, opioid analgesic-involved overdose deaths in 2013 were only twice that of heroin-involved deaths. Current cocaine users outnumbered heroin users by approximately 5 times in 2013, but heroin-involved overdose deaths were almost twice those of cocaine. Deaths involving heroin are also increasing at a much faster rate than for other illicit drugs, more than tripling between 2007 (2,402) and 2013 (8,260).<sup>9</sup> (See Chart 8.)

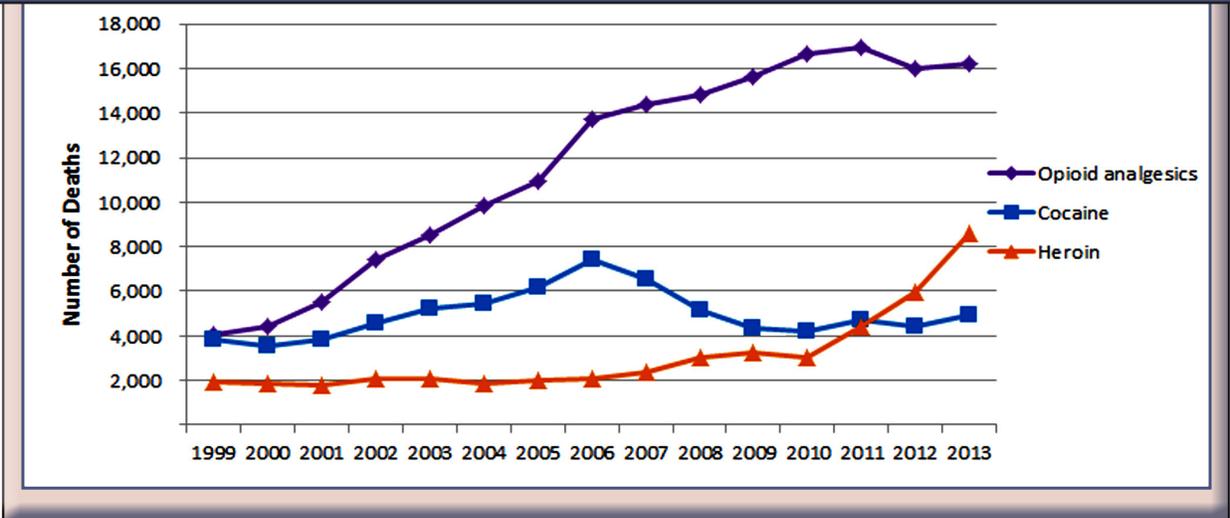


Note: Marijuana is not included on this chart because the user numbers are higher than for all other illicit drugs combined.

Source: National Survey on Drug Use and Health

(U) Heroin deaths are often undercounted because of variations in state reporting procedures, and because heroin metabolizes into morphine very quickly in the body, making it difficult to determine the presence of heroin. Many medical examiners are reluctant to characterize a death as heroin-related without the presence of 6-monoacetylmorphine (6-MAM), a metabolite unique to heroin, but which quickly metabolizes into morphine.<sup>10</sup> Thus many heroin deaths are reported as morphine-related deaths. Further, there is no standardized system for reporting drug-related deaths in the United States. The manner of collecting and reporting death data varies with each medical examiner and coroner.<sup>11</sup>

(U) Chart 8. Drug Poisoning Deaths Involving Selected Illicit Drugs, 1999 to 2013



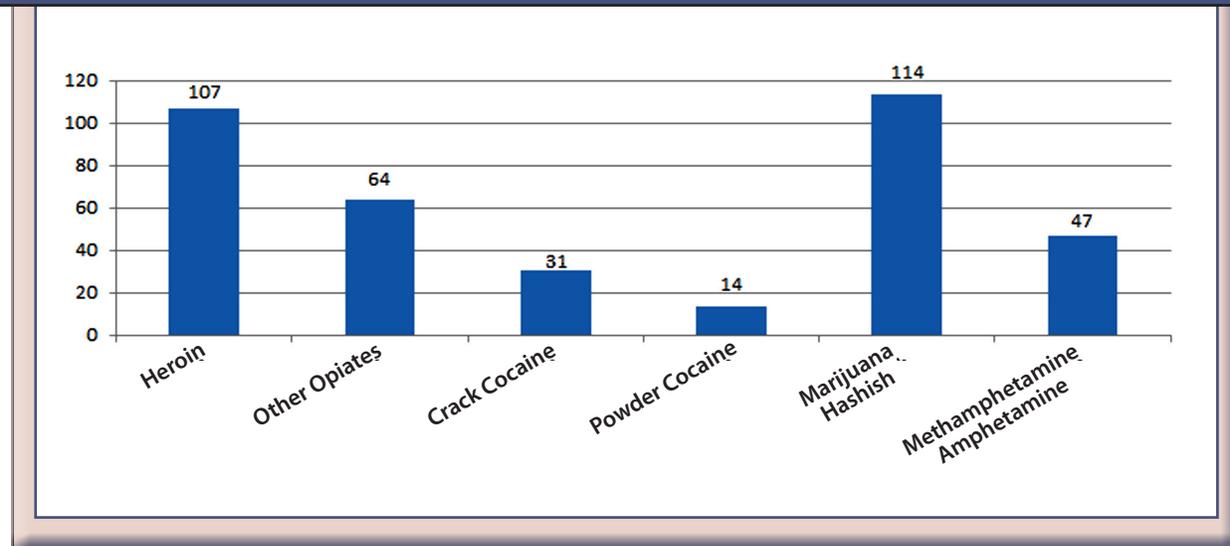
Note: Heroin includes opium.

Source: National Center for Health Statistics/CDC

- (U) More people seek treatment for heroin use than for any other illicit drug, except marijuana

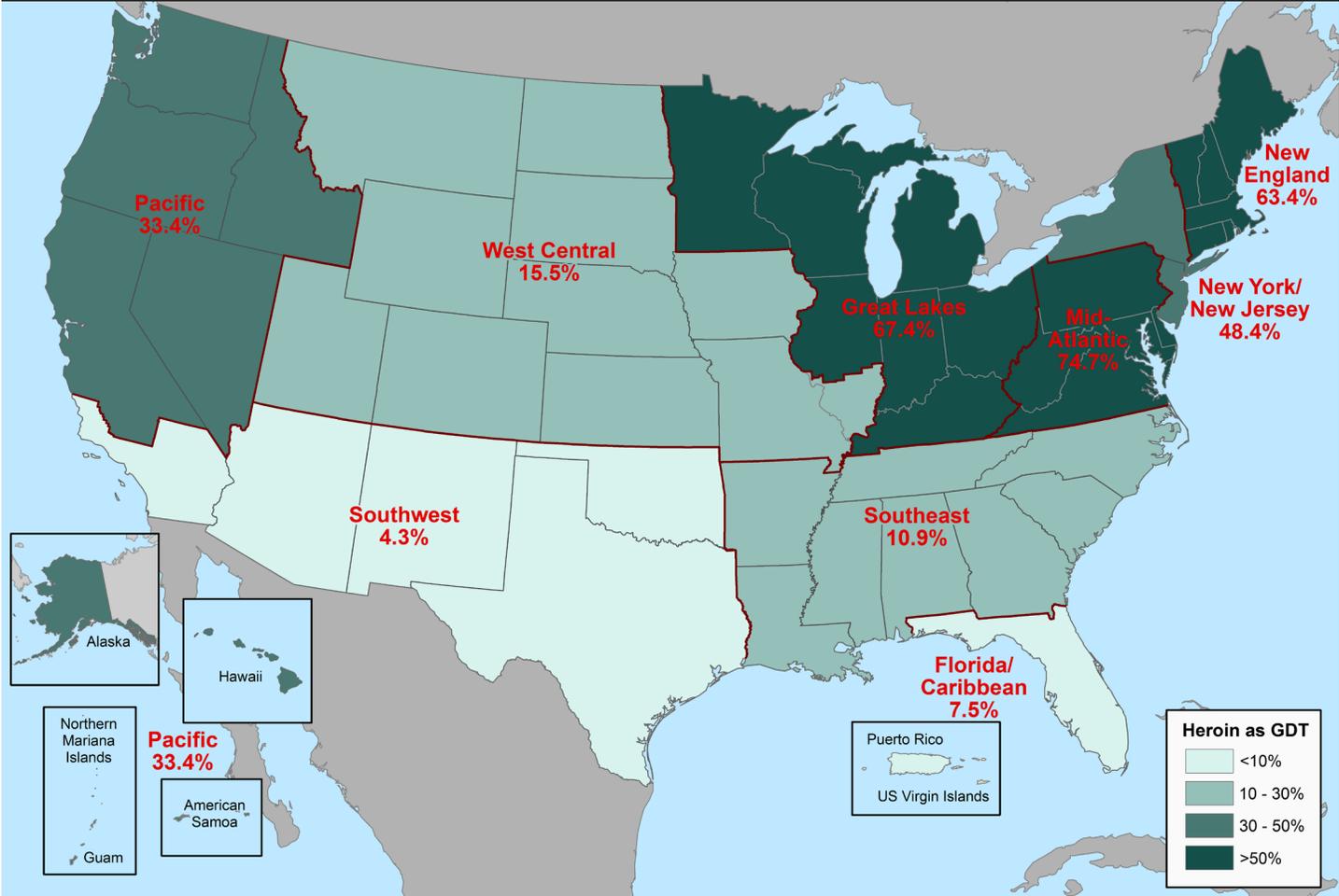
(U) Despite comprising a smaller user population, heroin had a higher rate for treatment admissions to publicly-funded facilities in 2012 (107 per 100,000) than any other illicit drug except marijuana. (See Chart 9.) Heroin treatment rates were almost equal to those of marijuana in 2012, despite the fact that current marijuana users outnumbered heroin users by a factor of 69.

(U) Chart 9. Illicit Drug Treatment Admissions to Publicly-Funded Facilities by Primary Drug, Rate Per 100,000, 2012



Source: Treatment Episode Data Set

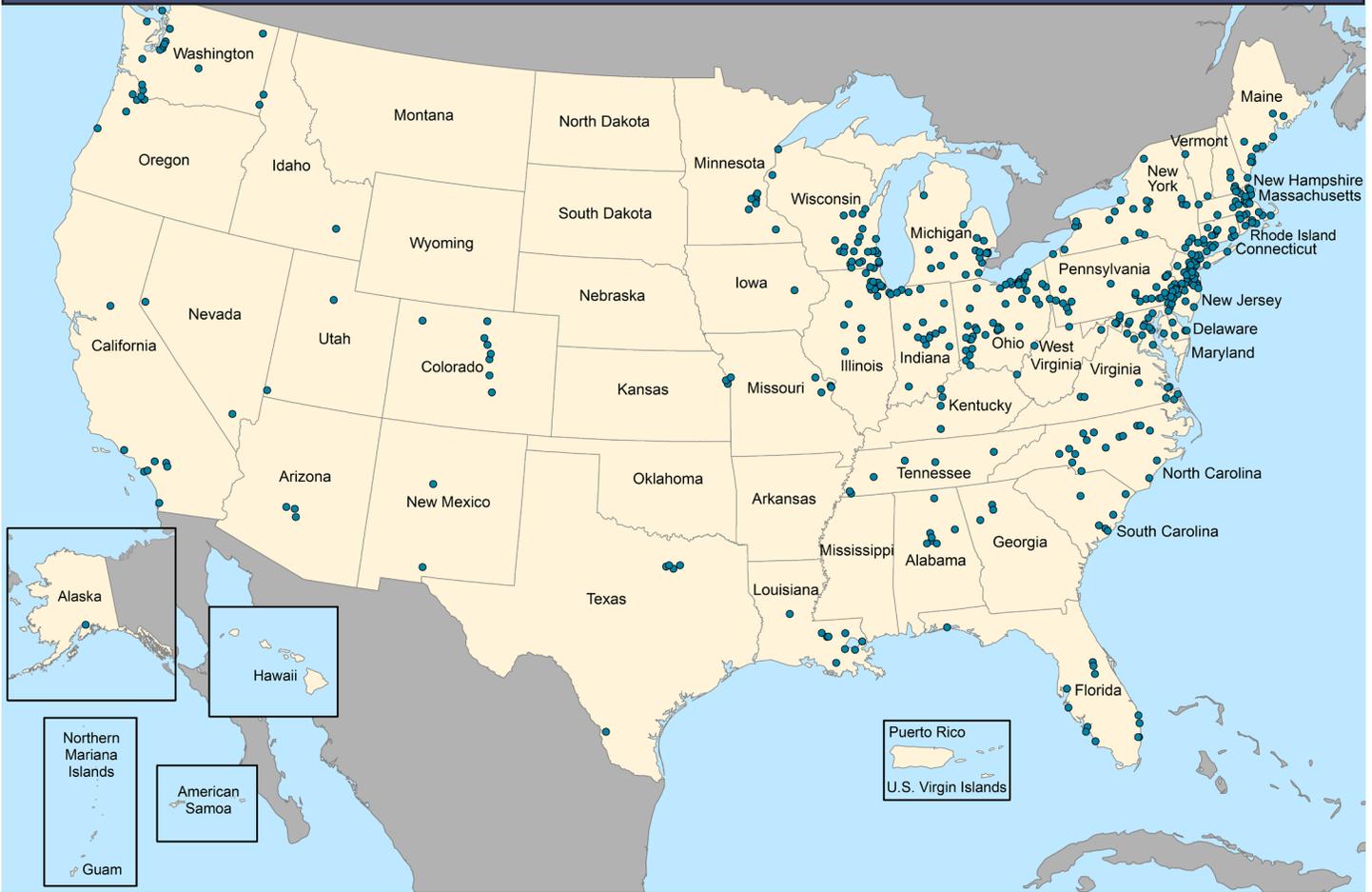
(U) Map 2. Percentage of 2015 NDTs Respondents Reporting Heroin as Greatest Drug Threat, by OCDETF Region



Source: 2015 National Drug Threat Survey

(U) The Organized Crime Drug Enforcement Task Force (OCDETF) Program was established in 1982 to conduct comprehensive, multi-level attacks on major drug trafficking and money laundering organizations. Today, OCDETF combines the resources and expertise of its member federal agencies which include: the Drug Enforcement Administration, the Federal Bureau of Investigation, the Bureau of Immigration and Customs Enforcement, the Bureau of Alcohol, Tobacco, Firearms and Explosives, the U.S. Marshals Service, the Internal Revenue Service, and the U.S. Coast Guard – in cooperation with the Department of Justice Criminal Division, the Tax Division, and the 94 U.S. Attorney’s Offices, as well as with state and local law enforcement. The principal mission of the OCDETF program is to identify, disrupt, and dismantle the most serious drug trafficking and money laundering organizations and those primarily responsible for the nation’s drug supply.

(U) Map 3. Locations of 2015 NDTs Respondents Reporting Heroin as Greatest Drug Threat



Source: 2015 National Drug Threat Survey

- <sup>1</sup> (U) U.S. Department of Justice, Drug Enforcement Administration, 2015 National Drug Threat Survey; U.S. Department of Justice, Drug Enforcement Administration, All Domestic Field Division Reporting, January 2013 – June, 2014.
- <sup>2</sup> (U) U.S. Department of Justice, Drug Enforcement Administration, All Domestic Field Division Reporting, January 2013 – June, 2014.
- <sup>3</sup> (U) U.S. Department of Justice, Drug Enforcement Administration, Chicago, New Jersey, New York, Philadelphia, and Washington Field Division Reporting, January 2015.
- <sup>4</sup> (U) U.S. Department of Justice, Drug Enforcement Administration, Historical Overview of the 2005 - 2006 Fentanyl Overdose 'Epidemic: Will History Repeat Itself? (Part 2 of 2), April 2015; U.S. Department of Justice, Drug Enforcement Administration, Detroit Field Division Reporting, email dated January 28, 2015.
- <sup>5</sup> (U) U.S. Department of Justice, Drug Enforcement Administration, DEA Investigative Reporting, January 2015.
- <sup>6</sup> (U) Office of National Drug Control Policy, National Drug Control Strategy Data Supplement 2014, September 2014.
- <sup>7</sup> (U) Cicero, Theodore J., PhD; Matthew S. Ellis, MPE; Hilary L. Surratt, PhD; Steven P. Kurtz, PhD, The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years, July 2014.

- <sup>8</sup> (U) Substance Abuse and Mental Health Services Administration, 2013 National Survey on Drug Use and Health, September 2014.
- <sup>9</sup> (U) Centers for Disease Control, National Center for Health Statistics, National Vital Statistics Report, Final death data for each calendar year, October 2014.
- <sup>10</sup> (U) Mayo Clinic, Mayo Medical Laboratories website, Clinical information on 6-Monoacetylmorphine, accessed January 13, 2015.
- <sup>11</sup> (U) Warner, Margaret PhD; Leonard J. Paulozzi MD MPH; Kurt B. Nolte MD; Gregory G. Davis MD MSPH; Lewis S. Nelson MD, State Variation In Certifying Manner of Death and Drugs Involved In Drug Intoxication Deaths, June 2013.

(U) This product was prepared by the DEA Strategic Intelligence Section. Comments and questions may be addressed to the Chief, Analysis and Production Section at [DEAIntelPublications@usdoj.gov](mailto:DEAIntelPublications@usdoj.gov).

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  <b>Nilajah Madison-Head, Bureau Assistant On Behalf of Tom Ryan, Executive Director</b>		2) Date When Request Submitted:  <b>04/30/15</b>  <small>Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting</small>	
3) Name of Board, Committee, Council, Sections:  <b>Medical Examining Board</b>			
4) Meeting Date:  <b>05/20/15</b>	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  <b>NC Dental Board v. FTC Decision – Board Discussion with Legal Counsel</b>	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:  N/A	
10) Describe the issue and action that should be addressed:  Guidance From Board Legal Counsel:  1. The Department is aware that on February 25, 2015, the U.S. Supreme Court issued a decision in North Carolina State Board of Dental Examiners v. Federal Trade Commission.  2. The Department, while continuing to analyze this decision, has developed preliminary opinions and guidance to regulatory boards.  a. This decision should not affect regulatory boards who are acting within their regulatory authority. For example, when a regulatory board disciplines a credential holder for unprofessional conduct, such board action is within the acceptable parameters of the board’s authority and should not trigger anti-trust issues. b. The investigation and discipline of unlicensed practice should be left to the Department. This has been the Department’s long-standing position and should not trigger anti-trust issues. c. The Department is, and has been, aware of potential anti-trust issues concerning regulatory boards. As such, this decision is not a surprise. d. The Department has consistently advised regulatory boards to act within their powers set out in the statutes. This advice remains the same following this decision. e. The Department will continue to analyze the decision and to monitor discussions about the decision especially in areas with potential anti-trust implications such as unlicensed practice, scope of practice and advertising. The Department will update the boards on any important developments.			
11) <i>Nilajah Madison-Head</i> Signature of person making this request		Authorization  <b>04/30/15</b> Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  Katie Paff Administrative Rules Coordinator		2) Date When Request Submitted:  5/5/2015  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections:  Medical Examining Board			
4) Meeting Date:  5/20/2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  Review of Legislative Report and Final Rule draft for Med 3, 5, 23 relating to physician licensure	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:  N/A	
10) Describe the issue and action that should be addressed:  The Board will review and approve the Legislative Report and Final Rule Draft for Med 3, 5, and 23 (CR15-022) for submission to the Governor's Office and Legislature.			
11) Authorization			
<b>Kathleen Paff</b>		<b>5/5/2015</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**STATE OF WISCONSIN  
MEDICAL EXAMINING BOARD**

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<b>IN THE MATTER OF RULEMAKING</b>	:	
<b>PROCEEDINGS BEFORE THE</b>	:	<b>REPORT TO THE LEGISLATURE</b>
<b>MEDICAL EXAMINING</b>	:	<b>CR 15-022</b>
<b>BOARD</b>	:	
	:	

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**I. THE PROPOSED RULE:**

The proposed rule, including the analysis and text, is attached.

**II. REFERENCE TO APPLICABLE FORMS:**

None.

**III. FISCAL ESTIMATE AND EIA:**

The Fiscal Estimate and EIA are attached.

**IV. DETAILED STATEMENT EXPLAINING THE BASIS AND PURPOSE OF THE PROPOSED RULE, INCLUDING HOW THE PROPOSED RULE ADVANCES RELEVANT STATUTORY GOALS OR PURPOSES:**

These rules address the changes instituted by the passage of 2013 Wisconsin Act 240 regarding physician licensure. The Act changed the postgraduate training requirement for all applicants seeking physician licensure from 12 months to 24 months. Both U.S. and foreign trained medical school graduates must complete 24 months of postgraduate training or must be currently enrolled and have successfully completed 12 months of a postgraduate training program, and have an unrestricted endorsement from the postgraduate training director that the applicant is expected to complete at least 24 months of postgraduate training.

Act 240 repealed the visiting professor license and created the restricted license to practice medicine and surgery as a visiting physician. The visiting physician license is open to any physician licensed outside of Wisconsin who is invited to serve on the academic staff of a medical school in this state. The holder of a visiting physician license may only practice in the education facility, research facility or medical school where the license holder is teaching, researching, or practicing medicine and surgery. The license is valid for one year and remains valid as long as the license holder is actively engaged in teaching, researching, or practicing medicine and surgery and is lawfully entitled to work in the U.S.

The temporary educational permit to practice medicine and surgery was also repealed and replaced with the resident educational license to practice medicine and surgery (REL). The REL allows the license holder to pursue postgraduate training under the direction of

a Wisconsin licensed physician. The holder of a REL may practice online in the postgraduate training program in which the person is being trained. The REL is valid for one year and may be renewed for additional one year terms as long as the license holder is enrolled in a postgraduate training program.

The Act created the administrative physician license. The administrative physician license allows the license holder to pursue administrative or professional managerial functions but does not allow the license holder to treat patients. The administrative physician license holder must comply with all of the same application requirements as a regular license to practice medicine and surgery.

**V. SUMMARY OF PUBLIC COMMENTS AND THE BOARD’S RESPONSES, EXPLANATION OF MODIFICATIONS TO PROPOSED RULES PROMPTED BY PUBLIC COMMENTS:**

The Medical Examining Board held a public hearing on April 15, 2015. The Board did not receive any written comments prior to the hearing. The Board did not receive testimony at the hearing.

**VI. RESPONSE TO LEGISLATIVE COUNCIL STAFF RECOMMENDATIONS:**

**Comment:** In Med 3.04, the word “the” before “medical school” could be deleted. Also, a comma should be inserted after the phrase “practicing medicine and surgery”, and the phrase “is limited to” should replace the phrase “only within”. Lastly, the reference to terms and restrictions “established by the board” is unclear. Is this intended to refer to individualized terms and restrictions for the visiting physician, or to terms and conditions given in the rule?

**Response:** “Established by the board” is intended to refer to individualized terms and restrictions for visiting physicians

All of the remaining recommendations suggested in the Clearinghouse Report have been accepted in whole.

**VII. REPORT FROM THE SBRRB AND FINAL REGULATORY FLEXIBILITY ANALYSIS:**

Not applicable.

STATE OF WISCONSIN  
MEDICAL EXAMINING BOARD

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IN THE MATTER OF RULEMAKING	:	PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE	:	MEDICAL EXAMINING BOARD
MEDICAL EXAMINING BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE 15-022)
	:	

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PROPOSED ORDER

The Medical Examining Board proposes an order to repeal Med 3.06; to amend Med 3 (title), 3.01, 3.02, 3.04, Med 5 (title), 5.01, 5.02, 5.04, and 5.05; to repeal and recreate Med 1.02 (3), 3.05 and 5.06; and to create Med 23, relating to physician licensure.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:**

448.04 (1) and 448.05 (2), Stats.

**Statutory authority:**

Sections 15.08 (5) (b), 227.11 (2) (a), 448.40 (1), Stats., and 2013 Wisconsin Act 240

**Explanation of agency authority:**

Sections 15.08 (5) (b) and 227.11 (2) (a), Stats., provide general authority from the legislature to the Medical Examining Board (Board) to promulgate rules that will provide guidance within the profession and interpret the statutes it administers. Section 448.40 (1), Stats., allows the Board to draft rules that will carry out the purposes of ch. 448, Stats. With the passage of 2013 Wisconsin Act 240, the legislature granted specific rule-making authority to the Board to draft rules to address the new physician licensure classifications created by the Act.

**Related statute or rule:**

Wis. Admin. Code ch. Med 1, 3, and 5

**Plain language analysis:**

These rules address the changes instituted by the passage of 2013 Wisconsin Act 240 regarding physician licensure. The Act changed the postgraduate training requirement for

all applicants seeking physician licensure from 12 months to 24 months. Both U.S. and foreign trained medical school graduates must complete 24 months of postgraduate training or must be currently enrolled and have successfully completed 12 months of a postgraduate training program, and have an unrestricted endorsement from the postgraduate training director that the applicant is expected to complete at least 24 months of postgraduate training.

Act 240 repealed the visiting professor license and created the restricted license to practice medicine and surgery as a visiting physician. The visiting physician license is open to any physician licensed outside of Wisconsin who is invited to serve on the academic staff of a medical school in this state. The holder of a visiting physician license may only practice in the education facility, research facility or medical school where the license holder is teaching, researching, or practicing medicine and surgery. The license is valid for one year and remains valid as long as the license holder is actively engaged in teaching, researching, or practicing medicine and surgery and is lawfully entitled to work in the U.S.

The temporary educational permit to practice medicine and surgery was also repealed and replaced with the resident educational license to practice medicine and surgery (REL). The REL allows the license holder to pursue postgraduate training under the direction of a Wisconsin licensed physician. The holder of a REL may practice online in the postgraduate training program in which the person is being trained. The REL is valid for one year and may be renewed for additional one year terms as long as the license holder is enrolled in a postgraduate training program.

The Act created the administrative physician license. The administrative physician license allows the license holder to pursue administrative or professional managerial functions but does not allow the license holder to treat patients. The administrative physician license holder must comply with all of the same application requirements as a regular license to practice medicine and surgery.

**Summary of, and comparison with, existing or proposed federal regulation:**

None.

**Comparison with rules in adjacent states:**

**Illinois:** Illinois requires 1 year of postgraduate clinical training for both US and Foreign graduates. 225 ILCS 60/11.

Visiting Professor Permit. This permit holder maintains a license to practice medicine in his or her native licensing jurisdiction during the period of the visiting professor permit and receives a faculty appointment to teach in a medical, osteopathic or chiropractic school in Illinois. A visiting professor permit is valid for 2 years from the date of its issuance or until the faculty appointment is terminated, whichever occurs first. 225 ILCS 60/18 (A.)

Visiting physician permit. This permit is granted to persons who have received an invitation or appointment to study, demonstrate or perform a specific medical, osteopathic, chiropractic or clinical subject or technique in a medical, osteopathic, or chiropractic school, a state or national medical, osteopathic, or chiropractic professional association or society conference or meeting, or a hospital licensed under the Hospital Licensing Act, a hospital organized under the University of Illinois Hospital Act, or a facility operated pursuant to the Ambulatory Surgical Treatment Center Act. The permit is valid for 180 days from the date of issuance or until the completion of the clinical studies or conference has concluded, whichever occurs first. 225 ILCS 60/18 (B)

Visiting resident permit. This permit is a credential that is issued to a candidate who maintains an equivalent credential in his or her native licensing jurisdiction during the period of the temporary visiting resident permit. The permit holder must be enrolled in a postgraduate clinical training program outside the state of Illinois and must have been invited or appointed for a specific time period to perform a portion of that postgraduate clinical training program under the supervision of an Illinois licensed physician in an Illinois patient care clinic or facility that is affiliated with the out-of-state post graduate training program. 225 ILCS 60/18 (C).

**Iowa:** Iowa requires one year of residency training in a hospital-affiliated program approved by the board, and graduates of international medical schools must complete 24 months of graduate training. 653 IAC 9.3.

The resident physician license allows the resident physician to practice under the supervision of a licensed practitioner in a board-approved resident training program in Iowa. The resident physician license is required of any resident physician enrolled in a resident training program and practicing in Iowa and can only remain active as long as the resident physician practices in the program designated in his or her application. If the resident physician leaves that program, the license immediately becomes inactive. 653 IAC 10.03 (1).

Special licensure is granted to physicians who are academic staff members of a school of medicine or osteopathic medicine if that physician does not meet the qualifications for permanent licensure but is held in high esteem for unique contributions that have been made to medicine. This class of licensure is renewed by the board on a case-by-case basis, and specifically limits the license to practice at the medical school and at any health care facility affiliated with the medical school. 653 IAC 10.4.

The Iowa Board does not have a comparable administrative physician license.

**Michigan:** Michigan requires graduates of schools located in the U.S. and its territories to complete 2 years of postgraduate clinical training. Mich. Admin. Code R. 338.2317. Foreign medical school graduates are required to complete 2 years of postgraduate clinical training in a program approved by the board, or in a board approved hospital or institution. Mich. Admin. Code R. 338.2316 (4) (a).

Clinical academic limited license. This credential is a class of licensure which is granted to candidates who have graduated from medical school and have been appointed to a teaching or research position in an academic institution. Mich. Admin. Code R. 338.2327a. This license holder must practice only for an academic institution and under the supervision of one or more physicians fully licensed in Michigan. This class of license is renewable on an annual basis but not past 5 years. MCLS §333.17030.

Educational limited license. This class of licensure authorizes the license holder to engage in the practice of medicine as part of a postgraduate educational training program. This license is granted to applicants who have graduated or who expect to graduate within the following 3 months from a medical school approved by the board where the applicant has been admitted to a training program approved by the board. Foreign trained applicants must complete a degree in medicine, have been admitted to a board approved training program, and have passed an examination in the basic and clinical medical sciences conducted by the educational commission for foreign medical graduates. Mich. Admin. Code R. 338.2329a.

Michigan does not have a comparable administrative physician license.

**Minnesota:** Minnesota requires U.S. or Canadian medical school graduates to complete 1 year of graduate clinical medical training. Minn. Stat. § 147.02 (d). Foreign medical school graduates must complete 2 years of graduate clinical medical training. Minn. Stat §147.037 (d).

Residency permit. A person must have a residency permit to participate in a residency program in Minnesota. If a resident permit holder changes a residency program, that person must notify the board in writing no later than 30 days after termination of participation in the residency program. A separate residency permit is required for each residency program until a license is obtained. Minn. Stat. §147.0391.

Minnesota exempts from licensure physicians that are employed in a scientific, sanitary, or teaching capacity by the state university, the Department of Education, a public or private school, school, or other bona fide educational institution, or in a nonprofit organization that operates primarily for the purpose of conducting scientific research directed towards discovering the causes of and cures for human diseases. Minn. Stat. §147.09 (6).

Minnesota does not have a comparable administrative physician license.

### **Summary of factual data and analytical methodologies:**

The methodologies used in drafting the proposed rules include reviewing 2013 Wisconsin Act 240 and obtaining feedback from members of the Medical Examining Board.

**Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:**

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Eric.Esser@wisconsin.gov, or by calling (608) 267-2435

**Effect on small business:**

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Eric.Esser@wisconsin.gov, or by calling (608) 267-2435

**Agency contact person:**

Kathleen Paff, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, Wisconsin 53708; telephone 608-261-4472; email at Kathleen.Paff@wisconsin.gov.

**Place where comments are to be submitted and deadline for submission:**

Comments may be submitted to Kathleen Paff, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, WI 53708-8935, or by email to Kathleen.Paff@wisconsin.gov. Comments must be received on or before April 15, 2015 to be included in the record of rule-making proceedings.

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TEXT OF RULE

SECTION 1. Med 1.02 (3) is repealed and recreated to read:

**Med 1.02 (3) (a)** A verified certificate showing satisfactory completion by the applicant of 24 months of postgraduate training in one or more programs accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or a successor organization; or documentary evidence that the applicant is currently enrolled in a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education, or the American Osteopathic Association or a successor organization and has received credit for 12 consecutive months of postgraduate training in that program and an unrestricted endorsement from the postgraduate training director that the applicant is expected to complete at least 24 months of postgraduate training.

(b) If an applicant is a graduate of a foreign medical school, then the applicant must provide a verified certificate showing satisfactory completion of 24 months of

postgraduate training in one or more programs accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or a successor organization; or documentary evidence that the applicant is currently enrolled in a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education, or the American Osteopathic Association or a successor organization and has received credit for 12 consecutive months of postgraduate training in that program and an unrestricted endorsement from the postgraduate training director that the applicant is expected to complete at least 24 months of postgraduate training.

(c) If the applicant is a graduate of a foreign medical school and has not completed 24 months of postgraduate training approved by the board and is not currently enrolled in a postgraduate training program but the applicant has other professional experience which the applicant believes has given that applicant the education and training substantially equivalent to 24 months of postgraduate training, then the applicant may submit the documented education and training illustrating substantially equivalent education and training. The board will review the documented education and training and may make further inquiry, including a personal interview of the applicant, as the board deems necessary to determine whether substantial equivalence in fact exists. The burden of proof of such equivalence shall lie upon the applicant. If the board finds that the documented education and training is substantially equivalent to the required training and experience the board may accept the experience in lieu of requiring the applicant to have completed 24 months of postgraduate training in a program approved by the board.

(d) The board approves of the training programs accredited by the following organizations: the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the Liaison Committee on Medical Education, and the National Joint Committee on Approval of Pre-Registration of Physician Training Programs of Canada, or their successor organizations.

SECTION 2. Med 1.06 (1) (a) (intro.), (b), and (c) are amended to read:

**Med 1.06 (1)** (a) All applicants shall complete the computer-based examination under sub. (3) (b), and an open book examination on statutes and rules governing the practice of medicine and surgery in Wisconsin. In addition, an applicant may be required to complete an oral ~~examination~~ interview if the applicant:

(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~~ interview.

(d) Written, and computer-based examinations and oral ~~examinations~~ interviews as required shall be scored separately and the applicant shall achieve a passing grade on all examinations to qualify for a license.

SECTION 3. Med 1.06 (4) is repealed.

SECTION 4. Med 1.08 (2) is amended to read:

**Med 1.08 (2)** If an applicant has been examined 4 or more times in another licensing jurisdiction in the United States or Canada before achieving a passing grade in written or computer-based examinations also required under this chapter, the board may require the applicant to submit evidence satisfactory to the board of further professional training or education in examination areas in which the applicant had previously demonstrated deficiencies. If the evidence provided by the applicant is not satisfactory to the board, the board may require the applicant to obtain further professional training or education as the board deems necessary to establish the applicant's fitness to practice medicine and surgery in this state. In order to determine any further professional training or education requirement, the board shall consider any information available relating to the quality of the applicant's previous practice, including the results of the applicant's performance on the oral ~~examination~~ interview required under s. 448.05 (6), Stats., and s. Med 1.06.

SECTION 5. Med 1.09 (1) is amended to read:

**Med 1.09 (1)** An applicant who fails the ~~oral-practical~~ or statutes and rules examination may request a review of that examination by filing a written request and required fee with the board within 30 days of the date on which examination results were mailed.

SECTION 6. Med 1.09 (4) is repealed.

SECTION 7. Med 1.09 (6) is amended to read:

**Med 1.09 (6)** At the beginning of the review, the applicant shall be provided with a copy of the questions, a copy of the applicant's answer sheet ~~or oral-practical tape~~ and a copy of the master answer sheet.

SECTION 8. Med 3 (title) is amended to read:

### CHAPTER MED 3

#### VISITING ~~PROFESSOR~~ PHYSICIAN LICENSE

SECTION 9. Med 3.01 and 3.02 are amended to read:

**Med 3.01 Authority and purpose.** The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.11 (2) (a) and 448.40, Stats., and govern application for a temporary license to practice medicine and surgery under s. 448.04 (1) (b) 2., Stats., restricted license to practice

medicine and surgery as a visiting physician under 448.04 (1) (bg), Stats., (hereinafter “visiting professor physician license”), and also govern practice thereunder.

**Med 3.02 Applications, credentials, and eligibility.** An applicant who is a graduate of a ~~foreign~~ an allopathic medical school located outside of the United States or Canada or an osteopathic medical school that is approved by the board and who is invited to serve on the academic staff of a medical school in this state as a ~~visiting professor physician~~ visiting physician may apply to the board for a ~~temporary visiting professor license~~ visiting physician license and shall submit to the board all of the following:

(1) A completed and verified application ~~for this purpose as required in s. Med 1.02 (1),~~ which includes proof that the applicant has graduated from and possesses a diploma from an allopathic medical or osteopathic medical school that is approved by the board.

(1m) Documentary evidence of licensure to practice medicine and surgery.

(2) A signed letter from the appointing authority president or dean or delegate of the president or dean of a medical school, or facility in this state indicating that the applicant has been invited to serve on the academic staff of such medical school as a visiting professor intends to teach, conduct research, or practice medicine and surgery at a medical education facility, medical research facility or medical school in this state.

(3) A curriculum vitae setting out the applicant's education and qualifications ~~and a verified photographic copy of the diploma (with translation) conferring the degree of doctor of medicine granted to the applicant by such college.~~

~~(4) A photograph of the applicant as required in s. Med 1.02 (4).~~

(5) A verified statement that the applicant is familiar with the state health laws and the rules of the department of health services as related to communicable diseases.

~~(6) Documentary evidence of noteworthy attainment in a specialized field of medicine.~~

(7) Documentary evidence of ~~post-graduate~~ postgraduate training completed in the United States ~~and/or~~ or foreign countries.

(8) Oral interview conducted ~~by~~ at the discretion of the board.

(9) Documentary evidence that the applicant teaches medicine, engages in medical research, or practices medicine and surgery outside of Wisconsin.

(10) The required fees determined under s. 440.03 (9) (a), Stats.

SECTION 10. Med 3.04 is amended to read:

**Med 3.04 Practice limitations.** The holder of a ~~temporary~~ visiting professor physician license may practice medicine and surgery as defined in s. 448.01 (9), Stats., providing such practice is ~~full-time and is~~ entirely limited to the medical education facility, medical research facility, or medical school where the license holder is teaching, conducting research, or practicing medicine and surgery, and is limited to the terms and restrictions established by the board. ~~the duties of the academic position to which the holder of such license is appointed.~~

SECTION 11. Med 3.05 is repealed and recreated to read:

**Med 3.05 Expiration and renewal.** A visiting physician license is valid for one year and remains valid only while the license holder is actively engaged in teaching, conducting research, or practicing medicine and surgery and is lawfully entitled to work in the United States. The visiting physician license may be renewed at the discretion of the board.

SECTION 12. Med 3.06 is repealed.

SECTION 13. Med 5 (title) is amended to read:

#### CHAPTER MED 5

#### TEMPORARY EDUCATIONAL PERMIT RESIDENT EDUCATIONAL LICENSE TO PRACTICE MEDICINE AND SURGERY

SECTION 14. Med 5.01 and 5.02 are amended to read:

**Med 5.01 Authority and purpose.** The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.11 and 448.40, Stats., and govern application for ~~temporary educational permit~~ the resident educational license to practice medicine and surgery under s. 448.04 (1) (e), Stats., s. 448.04 (1) (bm), Stats., (hereinafter "~~temporary resident educational permit license~~"), and also govern practice thereunder.

**Med 5.02 Applications, credentials, and eligibility.** An applicant who has been ~~appointed to~~ accepted into a postgraduate training program in a facility in this state approved by the board under the provisions of s. Med 1.02 (3) and accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or a successor organization may apply to the board for a ~~temporary educational permit~~ resident educational license to practice medicine and surgery ~~and~~. The applicant shall submit to the board all of the following:

(1) A completed and verified application form ~~supplied by the board for this purpose. These application forms are furnished by the board to the directors of training~~

~~programs in approved facilities in this state and are available to the applicant from such directors.~~

(1m) Documentary evidence that the applicant is a graduate of and possesses a diploma from a medical or osteopathic school approved by the board.

~~(2) The documentary~~ Documentary evidence that and credentials required under s. Med 1.02 (2), (4) and (5) the applicant has been accepted into a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or a successor organization.

(3) A signed letter from the president or dean or the delegate of the president or dean of the institution sponsoring the postgraduate training program into which the applicant has been accepted confirming that the applicant has been or will be accepted into a postgraduate training program.

(4) A verified statement that the applicant is familiar with the state health laws and rules of the department of health services as related to communicable diseases.

SECTION 15. Med 5.04 and 5.05 are amended to read:

**Med 5.04 Practice limitations.** ~~The holder of a temporary educational permit to practice medicine and surgery~~ resident educational license may, under the direction of a person licensed to practice medicine and surgery in this state, perform services requisite to the postgraduate training program in which that holder the licensee is serving. Acting under such direction, ~~the holder of such temporary educational permit~~ the resident educational licensee shall also have the right to prescribe drugs ~~other than narcotics and controlled substances~~ and to sign any certificates, reports or other papers for the use of public authorities which are required of or permitted to persons licensed to practice medicine and surgery. ~~The holder of such temporary educational permit~~ resident educational licensee shall confine ~~his or her~~ the training and entire practice to the facility postgraduate training program in which the permit holder the resident educational licensee is taking the training and to the duties of such training.

**Med 5.05 Revocation.** ~~Violation by the holder of a temporary educational permit~~ a resident educational licensee to practice medicine and surgery of any of the provisions of this chapter or of any of the provisions of the Wisconsin Administrative Code or of ch. 448, Stats., which apply to persons licensed to practice medicine and surgery shall be cause for the revocation of such ~~temporary educational permit~~ resident educational license.

SECTION 16. Med 5.06 is repealed and recreated to read:

**Med 5.06 Expiration and renewal.** A resident educational license to practice medicine and surgery granted under this chapter is valid for one year from the date of

issuance and may be renewed for additional one-year terms as long as the license holder is enrolled in the postgraduate training program.

SECTION 17. Ch. Med 23 is created to read:

## CHAPTER MED 23

### ADMINISTRATIVE PHYSICIAN LICENSE

**Med 23.01 Authority and purpose.** The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.11, and 448.40, Stats., and govern application for licensure as an administrative physician under s. 448.04 (1) (ac), Stats., and also govern practice thereunder.

**Med 23.02 Application, credentials and eligibility.** An applicant for an administrative physician license must provide a completed and verified application which includes proof that the applicant has graduated from and possesses a diploma from a medical or osteopathic school approved by the board; and documentary evidence of completion of a postgraduate training program approved by the board. Applicants for an administrative physician license must also meet the same qualifications for licensure as applicants applying under s. 448.05 (2) (a) or (b), Stats.

**Med 23.03 Fees.** The required fees must accompany the application, and must be made payable to the Wisconsin department of safety and professional services.

**Med 23.04 Practice limitations.** The Board may issue an administrative physician license to an applicant whose primary responsibilities are those of an administrative or academic nature, such as professional managerial, administrative, or supervisory activities. The holder of an administrative physician license may not examine, care for, or treat patients. An administrative physician license does not include the authority to prescribe drugs or controlled substances, delegate medical acts, issue opinions regarding medical necessity, or conduct clinical trials on humans.

**Med 23.05 Registration and renewal.** Each administrative physician licensee shall register biennially with the board. Administrative physicians who possess the degree of doctor of osteopathy must register by March 1<sup>st</sup> of each even-numbered year. Administrative physicians who possess the degree of doctor of medicine must register on or before November 1 of each odd-numbered year. The department shall mail to each licensee at his or her last known address as it appears in the records of the board a notice of renewal for registration. The board shall notify the licensee within 30 business days of receipt of a completed registration form as to whether the application for registration is approved or denied. The administrative physician licensee must comply with all other provisions of s. 448.13, Stats. and of ch. Med 13.

**Med 23.06 Interview.** Applicants may be required to complete an oral interview at the discretion of the board.

SECTION 18. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, pursuant to s. 227.22 (2) (intro.), Stats.

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(END OF TEXT OF RULE)  
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This Proposed Order of the Medical Examining Board is approved for submission to the Governor's office.

Dated \_\_\_\_\_

Agency \_\_\_\_\_

Chairperson  
Medical Examining Board

## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

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1. Type of Estimate and Analysis

Original  Updated  Corrected

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2. Administrative Rule Chapter, Title and Number

Med 1, 3 and 5

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3. Subject

Physician licensure

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4. Fund Sources Affected

GPR  FED  PRO  PRS  SEG  SEG-S

5. Chapter 20, Stats. Appropriations Affected

20.165 (1) (hg)

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6. Fiscal Effect of Implementing the Rule

No Fiscal Effect  Increase Existing Revenues  Increase Costs  
 Indeterminate  Decrease Existing Revenues  Could Absorb Within Agency's Budget  
 Decrease Cost

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7. The Rule Will Impact the Following (Check All That Apply)

State's Economy  Specific Businesses/Sectors  
 Local Government Units  Public Utility Rate Payers  
 Small Businesses (if checked, complete Attachment A)

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8. Would Implementation and Compliance Costs Be Greater Than \$20 million?

Yes  No

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9. Policy Problem Addressed by the Rule

This proposed rule addresses a policy change instituted by recent legislation, specifically 2013 Wisconsin Act 240. This legislation transformed physician licensure in Wisconsin by discontinuing the visiting professor license and the temporary educational license and creating three new licensure classes. One of the new licensure classes is the visiting physician license. The visiting physician license is open to candidates from outside of Wisconsin who have been invited to serve on the academic staff of a medical school in this state. The visiting physician license holder must limit their teaching, researching, and practice of medicine to the education facility, research facility or college where the visiting physician licensee has been invited to teach, research, or practicing medicine. The resident education license allows new medical school graduates to become licensed in order to complete their postgraduate training. The resident educational license holder must practice medicine and surgery only in connection with his or her duties under their postgraduate training program. Lastly, the administrative physician license allows the license holder to pursue professional managerial functions but does not allow treating patients. The Act also increased the required graduate medical educational training from one year to two years. The proposed rule seeks to amend Wis. Admin. Code s. Med 1, 3, and 5 to reflect these changes.

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10. Summary of the businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule that were contacted for comments.

The proposed rule was posted on the Department of Safety and Professional Services' website for 14 days in order to solicit comments from businesses, associations representing businesses, local governmental units and individuals that may be affected by the rule. No comments were received.

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11. Identify the local governmental units that participated in the development of this EIA.

No local government units participated in the development of this EIA.

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12. Summary of Rule's Economic and Fiscal Impact on Specific Businesses, Business Sectors, Public Utility Rate Payers, Local Governmental Units and the State's Economy as a Whole (Include Implementation and Compliance Costs Expected to be Incurred)

This proposed rule will have minimal or no economic impact on specific businesses, business sectors, public utility rate payers, local government units or the state's economy as a whole.

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## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

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13. Benefits of Implementing the Rule and Alternative(s) to Implementing the Rule

The benefit of implementing this proposed rule includes carrying out the statutory goals of 2013 Wisconsin Act 240 and giving clear guidance on the requirements for licensure to those applying for a license to practice medicine and surgery in Wisconsin.

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14. Long Range Implications of Implementing the Rule

Long range implications of implementing the rule include greater consistency in the licensure process for applicants seeking to practice medicine and surgery in Wisconsin.

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15. Compare With Approaches Being Used by Federal Government

None.

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16. Compare With Approaches Being Used by Neighboring States (Illinois, Iowa, Michigan and Minnesota)

**Illinois:** Illinois requires 1 year of postgraduate clinical training for both US and Foreign graduates. 225 ILCS 60/11.

Visiting Professor Permit This permit holder maintains a license to practice medicine in his or her native licensing jurisdiction during the period of the visiting professor permit and receives a faculty appointment to teach in a medical, osteopathic or chiropractic school in Illinois. A visiting professor permit is valid for 2 years from the date of its issuance or until the faculty appointment is terminated, whichever occurs first. 225 ILCS 60/18 (A.)

Visiting physician permit This permit is granted to persons who have received an invitation or appointment to study, demonstrate or perform a specific medical, osteopathic, chiropractic or clinical subject or technique in a medical, osteopathic, or chiropractic school, a state or national medical, osteopathic, or chiropractic professional association or society conference or meeting, or a hospital licensed under the Hospital Licensing Act, a hospital organized under the University of Illinois Hospital Act, or a facility operated pursuant to the Ambulatory Surgical Treatment Center Act. The permit is valid for 180 days from the date of issuance or until the completion of the clinical studies or conference has concluded, whichever occurs first. 225 ILCS 60/18 (B)

Visiting resident permit is a credential that is issued to candidates who maintain an equivalent credential in his or her native licensing jurisdiction during the period of the temporary visiting resident permit. The permit holder must be enrolled in a postgraduate clinical training program outside the state of Illinois and must have been invited or appointed for a specific time period to perform a portion of that postgraduate clinical training program under the supervision of an Illinois licensed physician in an Illinois patient care clinic or facility that is affiliated with the out-of-state post graduate training program. 225 ILCS 60/18 (C).

**Iowa:** Iowa requires one year of residency training in a hospital-affiliated program approved by the board, graduates of international medical schools must complete 24 months of graduate training. 653 IAC 9.3.

Resident physician license allows the resident physician to practice under the supervision of a licensed practitioner in a board-approved resident training program in Iowa. The resident physician licensure is required of any resident physician enrolled in a resident training program and practicing in Iowa and can only remain active as long as the resident physician practices in the program designated in his or her application. If the resident physician leaves that program, the license immediately becomes inactive. 653 IAC 10.03 (1).

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## **ADMINISTRATIVE RULES**

### **Fiscal Estimate & Economic Impact Analysis**

Special licensure is granted to physicians who are academic staff members of a college of medicine or osteopathic medicine if that physician does not meet the qualifications for permanent licensure but is held in high esteem for unique contributions that have been made to medicine. This class of licensure is renewed by the board on a case-by-case basis, and specifically limits the license to practice at the medical college and at any health care facility affiliated with the medical college. 653 IAC 10.4.

The Iowa Board did not have a comparable administrative physician license.

**Michigan:** Michigan requires graduates of schools located in the U.S. and its territories to complete 2 years of postgraduate clinical training. Mich. Admin. Code R. 338.2317. Foreign medical school graduates are required to complete 2 years of postgraduate clinical training in a program approved by the board, or in a board approved hospital or institution. Mich. Admin. Code R. 338.2316 (4) (a).

Clinical academic limited license is a class of licensure which is granted to candidates who have graduated from medical school and have been appointed to a teaching or research position in an academic institution. Mich. Admin. Code R. 338.2327a. This license holder must practice only for an academic institution and under the supervision of one or more physicians fully licensed in Michigan. This class of license is renewable on an annual basis but not past 5 years. MCLS §333.17030.

Educational limited license This class of licensure authorizes the license holder to engage in the practice of medicine as part of a postgraduate educational training program. This license is granted to applicants who have graduated or who expect to graduate within the following 3 months from a medical school approved by the board and that the applicant has been admitted to a training program approved by the board. Foreign trained applicants must verify that they have completed a degree in medicine, have been admitted to a board approved training program and have passed an examination in the basic and clinical medical sciences conducted by the educational commission for foreign medical graduates. Mich. Admin. Code R. 338.2329a.

Michigan does not have a comparable administrative physician license.

**Minnesota:** Minnesota requires U.S. or Canadian medical school graduates to complete 1 year of graduate clinical medical training. Minn. Stat. § 147.02 (d). Foreign medical school graduates must complete 2 years of graduate clinical medical training. Minn. Stat §147.037 (d).

Residency permit A person must have a residency permit to participate in residency program in Minnesota. If a resident permit holder changes their residency program, that person must notify the board in writing no later than 30 days after termination of participation in the residency program. A separate residency permit is required for each residency program until a license is obtained. Minn. Stat. §147.0391.

Minnesota exempts from licensure physicians that are employed in a scientific, sanitary, or teaching capacity by the state university, the Department of Education, a public or private school, college, or other bona fide educational institution, or nonprofit organizations operated primarily for the purpose of conducting scientific research directed towards discovering the causes of and cures for human diseases. Minn. Stat. §147.09 (6).

**ADMINISTRATIVE RULES**  
**Fiscal Estimate & Economic Impact Analysis**

Minnesota does not have a comparable administrative physician license.

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17. Contact Name

Shawn Leatherwood

18. Contact Phone Number

608-261-4438

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This document can be made available in alternate formats to individuals with disabilities upon request.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  Katie Paff Administrative Rules Coordinator		2) Date When Request Submitted:  5/5/2015  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections:  Medical Examining Board			
4) Meeting Date:  5/20/2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  Update on Med 13 (CR14-033) relating to continuing education audits and Med 18 (CR14-040) relating to physicians and informed consent	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:  N/A	
10) Describe the issue and action that should be addressed:  Med 13 and Med 18 were signed for adoption on April 15, 2015. These rules will take effect on June 1 <sup>st</sup> , 2015.			
11) Authorization			
<b>Kathleen Paff</b>		<b>5/5/2015</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

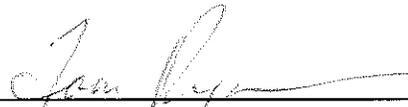
**CERTIFICATE**

**STATE OF WISCONSIN  
DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES**

*I, Tom Ryan, Executive Director, Division of Policy Development in the Wisconsin Department of Safety and Professional Services and custodian of the official records of the Medical Examining Board, do hereby certify that the annexed rules were duly approved and adopted by the Medical Examining Board on the 15 day of April, 2015.*

*I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.*

*IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the board at 1400 East Washington Avenue, Madison, Wisconsin this 15 day of April, 2015.*



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**Tom Ryan, Executive Director  
Division of Policy Development  
Department of Safety & Professional Services**

STATE OF WISCONSIN  
MEDICAL EXAMINING BOARD

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IN THE MATTER OF RULEMAKING	:	ORDER OF THE
PROCEEDINGS BEFORE THE	:	MEDICAL EXAMINING BOARD
MEDICAL EXAMINING BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE 14-033)

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ORDER

An order of the Medical Examining Board to amend Med 13.06 relating to continuing education audits.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:**

Section 448.13 (1m), Stats.

**Statutory authority:**

Sections 15.08 (5) (b), 227.11 (2) (a), and 448.13, Stats.

**Explanation of agency authority:**

Pursuant to ss. 15.08 (5) (b) and 227.11 (2) (a), Stats., the Medical Examining Board, (Board), is generally empowered by the legislature to promulgate rules that will provide guidance within the profession and rules that interpret the statutes it enforces or administers. The Board administers s. 448.13, Stats., which sets forth the Board's authority to conduct random audits of continuing education compliance. The proposed rule seeks to require the performance of audits every two years in accordance with s. 448.13 (1m), Stats. Therefore, the Board is both generally and specifically empowered to promulgate the proposed rule.

**Related statute or rule:**

None.

**Plain language analysis:**

The Medical Examining Board reviewed its administrative rules and determined that there was no mechanism to require regular audits of licensees' compliance with the continuing education requirement specified s. Med 13.02 (1). The Board sought to rectify the matter by requiring a random audit of licensees' continuing education compliance

every two years. Auditing licensees' compliance with the continuing education requirement will act as a deterrent to non-compliance and ensure licensees are maintaining their skills in keeping with the highest standards within the profession.

**Summary of, and comparison with, existing or proposed federal regulation:**

None.

**Comparison with rules in adjacent states:**

**Illinois:** Licensees in Illinois have a 36 month renewal cycle in which they must complete 150 hours of continuing medical education. Applicants are required to certify on their renewal application that they have complied with the continuing education requirement. It is the responsibility of each renewal applicant to retain or otherwise produce additional evidence of compliance in case of a random audit. ILL. ADMIN. CODE tit. 68 §1285.110 d).

**Iowa:** Licensees are required to maintain documentation evidencing completion of continuing education for five years after the date of continuing education and training. Conducting an audit is not compulsory but if an audit is conducted the licensee must respond within 30 days of a request made by the board. IOWA ADMIN. CODE r. 653-11.4 (7).

**Michigan:** Licensees must complete 150 hours of continuing education in 3 years. Licensees certify at the time of renewal that they have completed the required continuing education and must retain evidence of his or her compliance for a period of 4 years from the date of application. MICH. ADMIN. CODE r. 388.2381.

**Minnesota:** Minnesota has a 3 year cycle in which to complete 75 hours of continuing education. Licensees provide a signed statement to the board indicating compliance. Licensees that fail to comply are subject to discipline. Minn. R. 5605.0100.

**Summary of factual data and analytical methodologies:**

The Board reviewed its current administrative rules and observed that the rules did not require a standardized audit of licensees' compliance with continuing education requirement. The proposed rule seeks to address this concern. No other factual data or analytical methodologies were used. The Board ensures the accuracy, integrity, objectivity and consistency of data were used in preparing the proposed rule and related analysis.

**Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:**

The rule was posted for public comment on the economic impact of the proposed rule, including how this proposed rule may affect businesses, local government units, and individuals, for a period of 14 days. No comments were received relating to the economic impact of the rule.

**Fiscal Estimate and Economic Impact Analysis:**

The Fiscal Estimate and Economic Impact Analysis are attached.

**Effect on small business:**

The proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Eric.Esser@wisconsin.gov, or by calling (608) 267-2435.

**Agency contact person:**

Katie Paff, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, Wisconsin 53708; telephone (608) 261-4472; email at Kathleen.Paff@wisconsin.gov.

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TEXT OF RULE

SECTION 1. MED 13.06 is amended to read:

Med 13.06 The board shall conduct a random audit of licensees on a biennial basis for compliance with the continuing education requirement stated in s. Med 13.02 (1). The board may require any physician to submit evidence of compliance with the continuing education requirement to the board during the biennium for which 30 hours of credit are required for registration to audit compliance.

SECTION 2. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, pursuant to s. 227.22 (2) (intro.), Stats.

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(END OF TEXT OF RULE)  
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Dated

April 15, 2015

Agency



Chairperson

Medical Examining Board

## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

1. Type of Estimate and Analysis

Original    Updated    Corrected

2. Administrative Rule Chapter, Title and Number

Med 13.06

3. Subject

Continuing education audits

4. Fund Sources Affected

GPR    FED    PRO    PRS    SEG    SEG-S

5. Chapter 20, Stats. Appropriations Affected

20.165(1) (hg)

6. Fiscal Effect of Implementing the Rule

No Fiscal Effect    Increase Existing Revenues    Increase Costs  
 Indeterminate    Decrease Existing Revenues    Could Absorb Within Agency's Budget  
 Decrease Cost

7. The Rule Will Impact the Following (Check All That Apply)

State's Economy    Specific Businesses/Sectors  
 Local Government Units    Public Utility Rate Payers  
 Small Businesses (if checked, complete Attachment A)

8. Would Implementation and Compliance Costs Be Greater Than \$20 million?

Yes    No

9. Policy Problem Addressed by the Rule

The Medical Examining Board reviewed its administrative rules concerning continuing education and determined that licensees were not being regularly audited for compliance with the continuing education requirement specified in s. Med 13.02 (1). The Board concluded that mandatory audits should take place every two years to ensure that licensees are acquiring the required 30 hours of continuing education. The proposed rule will amend s. Med 13.06 to reflect that change.

10. Summary of the businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule that were contacted for comments.

The rule was posted on the Department of Safety and Professional Service's website for 14 days in order to solicit comments from businesses, associations representing businesses, local governmental units and individuals that may be affected by the rule. No comments were received.

11. Identify the local governmental units that participated in the development of this EIA.

No local governmental units participated in the development of this EIA.

12. Summary of Rule's Economic and Fiscal Impact on Specific Businesses, Business Sectors, Public Utility Rate Payers, Local Governmental Units and the State's Economy as a Whole (Include Implementation and Compliance Costs Expected to be Incurred)

This proposed rule will not have a significant impact on specific businesses, business sectors, public utility rate payers, local governmental units or the state's economy as a whole.

13. Benefits of Implementing the Rule and Alternative(s) to Implementing the Rule

The benefit of implementing the rule ensures that licensees will maintain their skill level and knowledge base by maintaining their required 30 hours of continuing education.

14. Long Range Implications of Implementing the Rule

Implementing the proposed rule will act as a deterrent to non-compliance with the continuing education requirement.

15. Compare With Approaches Being Used by Federal Government

None.

**ADMINISTRATIVE RULES**  
**Fiscal Estimate & Economic Impact Analysis**

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16. Compare With Approaches Being Used by Neighboring States (Illinois, Iowa, Michigan and Minnesota)

**Illinois:** Licensees in Illinois have a 36 month renewal cycle in which they must complete 150 hours of continuing medical education. Applicants are required to certify on their renewal application that they have complied with the continuing education requirement. It is the responsibility of each renewal applicant to retain or otherwise produce additional evidence of compliance in case of a random audit. ILL. ADMIN. CODE tit. 68 §1285.110 d).

**Iowa:** Licensees are required to maintain documentation evidencing completion of continuing education for five years after the date of continuing education and training. Conducting an audit is not compulsory but if an audit is conducted the licensee must respond within 30 days of a request made by the board. IOWA ADMIN. CODE r. 653-11.4 (7).

**Michigan:** Licensees must complete 150 hours in 3 years. Licensees certify at the time of renewal that they have completed the required continuing education and must retain evidence of his or her compliance for a period of 4 years from the date of application. MICH. ADMIN. CODE r. 388.2381.

**Minnesota:** Minnesota has a 3 year cycle in which to complete 75 hours of continuing education. Licensees provide a signed statement to the board indicating compliance. Licensees that fail to comply are subject to discipline. Minn. R. 5605.0100.

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17. Contact Name

Katie Paff

18. Contact Phone Number

608-261-4472

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This document can be made available in alternate formats to individuals with disabilities upon request.

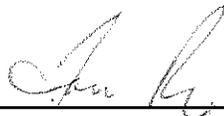
**CERTIFICATE**

**STATE OF WISCONSIN  
DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES**

*I, Tom Ryan, Executive Director, Division of Policy Development in the Wisconsin Department of Safety and Professional Services and custodian of the official records of the Medical Examining Board, do hereby certify that the annexed rules were duly approved and adopted by the Medical Examining Board on the 15 day of April, 2015.*

*I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.*

*IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the board at 1400 East Washington Avenue, Madison, Wisconsin this 15 day of April, 2015.*



---

*Tom Ryan, Executive Director  
Division of Policy Development  
Department of Safety & Professional Services*

STATE OF WISCONSIN  
MEDICAL EXAMINING BOARD

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IN THE MATTER OF RULEMAKING	:	ORDER OF THE
PROCEEDINGS BEFORE THE	:	MEDICAL EXAMINING BOARD
MEDICAL EXAMINING BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE 14-040)

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ORDER

An order of the Medical Examining Board to amend Med 18.02 (3), 18.04 (3) and (5) and 18.05; to repeal and recreate chapter Med 18 (title) Med 18.03 (title); and to create Med 18.04 (6), relating to physicians and informed consent.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:**

Section 448.30, Stats.

**Statutory authority:**

Sections 15.08 (5) (b), 227.11 (2) (a), and 448.40 (2) (a), Stats., 2013 Wisconsin Act 111

**Explanation of agency authority:**

Examining boards are authorized by s. 15.08 (5) (b), Stats., to promulgate rules that will provide guidance within their profession. Section 227.11 (2) (a), Stats., grants authority to boards to promulgate rules interpreting the statutes it enforces or administers as long as the proposed rule does not exceed proper interpretation of the statute. This proposed rule will interpret s. 448.30, Stats., which sets forth the guidelines physicians must follow in order to properly inform their patients regarding alternate modes of treatment. Section 448.40 (2) (a), Stats., grants express authority from the legislature to the Medical Examining Board to draft rules regarding informed consent.

**Related statute or rule:**

None.

**Plain language analysis:**

Recent legislation, 2013 Wisconsin Act 111, significantly impacted s. 448.30, Stats., and Wis. Admin Code s. Med 18. Before the Act, physicians had a duty to inform their

patients, under s. 448.30, Stats., of all alternate viable medical modes of treatment and about the benefits and risks of those treatments. After the passage of Act 111, physicians are required to inform their patients of reasonable alternate medical modes of treatment. The latter standard is not as broad as the former standard and in fact lessens the burden on physicians.

Another major change is the reasonable physician standard has replaced the reasonable patient standard. The reasonable physician standard requires doctors to disclose only the information that a reasonable physician in the same or similar medical specialty would know and disclose under the circumstances. The reasonable patient standard requires a physician to disclose information necessary for a reasonable person to make an intelligent decision with respect to the choices of treatment. The reasonable physician standard is a more objective approach and is the standard to which Wisconsin physicians must now adhere.

**Summary of, and comparison with, existing or proposed federal regulation:**

Several federal agencies, including but not limited to the Food and Drug Administration, have rules protecting human subjects participating in investigative trials. Investigators are required to obtain informed consent of each person that will participate in experimental studies, 21 CFR 50.20, including experiments involving drugs for human use found in 21 CFR 312.60. Obtaining informed consent from participants in the investigatory research is not intended to preempt any applicable federal, state, or local laws which require additional information to be disclosed in order for **informed consent** to be legally effective.

**Comparison with rules in adjacent states:**

**Illinois:** Illinois does not have a comparable statute or rule.

**Iowa:** Iowa statutes create a presumption that informed consent was given if it is documented in writing. "A consent in writing to any medical or surgical procedure or course of procedure in patient care which meets the requirements of this section shall create a presumption that informed consent was given." IOWA CODE § 147.137.

**Michigan:** Michigan's statute has comparable language which is directed towards physicians who are treating breast cancer patients. Physicians are required to inform patients verbally and in writing about alternative modes of treatment of cancer. The statute sets forth the reasonable physician standards. "A physician's duty to inform a patient under this section does not require disclosure of information beyond what a reasonably well-qualified physician licensed under this article would know." MCLS §333.17013 (6).

**Minnesota:** Minnesota does not have comparable statute or rule.

**Summary of factual data and analytical methodologies:**

No factual data was required for the rule-making in this proposal, due to the changes being necessitated by the passage of 2013 Wisconsin Act 111. For that reason, no factual data or analytical methodologies were used in the preparation of these proposed rules.

**Analysis and supporting documents used to determine effect on small business or in preparation of economic impact report:**

The rule was posted for public comment on the economic impact of the proposed rule, including how this proposed rule may affect businesses, local government units, and individuals, for a period of 14 days. No comments were received relating to the economic impact of the rule.

**Fiscal Estimate and Economic Impact Analysis:**

The Fiscal Estimate and Economic Impact Analysis is attached.

**Effect on small business:**

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Eric.Esser@wisconsin.gov, or by calling (608) 267-2435.

**Agency contact person:**

Katie Paff, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, Wisconsin 53708; telephone (608) 261-4472; email at Kathleen.Paff@wisconsin.gov.

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TEXT OF RULE

SECTION 1. Chapter Med 18 (title) is repealed and recreated to read:

CHAPTER MED 18 (title)  
INFORMED CONSENT

SECTION 2. Med 18.02 (3) is amended to read:

**Med 18.02 (3)** ~~“Viable” as used in s. 448.30, Stats., to modify the term “medical modes of treatment” means modes of treatment~~ **“Modes of treatment” means treatment, including diagnostic procedures,** generally considered by the medical profession to be within the scope of current, acceptable standards of care.

SECTION 3. Med 18.03 is repealed and recreated to read:

**Med 18.03 (title) Informed consent.** Any physician who treats a patient shall inform the patient about the availability of reasonable alternate medical modes of treatment and about the benefits and risks of these treatments. The reasonable physician standard is the standard for informing a patient. The reasonable physician standard requires disclosure only of information that a reasonable physician in the same or a similar medical specialty would know and disclose under the circumstances.

SECTION 4. Med 18.04 (3) and (5) are amended to read:

**Med 18.04 (3)** A physician is not required to communicate any mode of treatment which is not ~~viable~~ a reasonable alternate mode of treatment or which is experimental.

**Med 18.04 (5)** A physician may simplify or omit communication of ~~viable~~ reasonable alternate modes of treatment if the communication would unduly confuse or frighten a patient or if a patient refuses to receive the communication.

SECTION 5. Med 18.04 (6) is created to read:

**Med 18.04 (6)** A physician is not required to communicate information about alternate medical modes of treatment for any condition the physician has not included in his or her diagnosis at the time the physician informs the patient.

SECTION 6. Med 18.05 is amended to read:

**Med 18.05 Recordkeeping.** A physician shall indicate on a patient's medical record he or she has communicated to the patient reasonable alternate ~~viable~~ modes of treatment.

SECTION 7. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, pursuant to s. 227.22 (2) (intro.), Stats.

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(END OF TEXT OF RULE)  
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Dated

April 15, 2015

Agency



Chairperson  
Medical Examining Board

## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

1. Type of Estimate and Analysis

Original    Updated    Corrected

2. Administrative Rule Chapter, Title and Number

Med 18

3. Subject

Informed consent

4. Fund Sources Affected

GPR    FED    PRO    PRS    SEG    SEG-S

5. Chapter 20, Stats. Appropriations Affected

6. Fiscal Effect of Implementing the Rule

No Fiscal Effect    Increase Existing Revenues    Increase Costs  
 Indeterminate    Decrease Existing Revenues    Could Absorb Within Agency's Budget  
 Decrease Cost

7. The Rule Will Impact the Following (Check All That Apply)

State's Economy    Specific Businesses/Sectors  
 Local Government Units    Public Utility Rate Payers  
 Small Businesses (if checked, complete Attachment A)

8. Would Implementation and Compliance Costs Be Greater Than \$20 million?

Yes    No

9. Policy Problem Addressed by the Rule

This proposed rule is a result of recent legislation, 2013 Wisconsin Act 111 changed the standard regarding doctors informing patients of their health care options by removing the reasonable patient standard and replacing it with the reasonable physician standard. The reasonable physician standard requires doctors to disclose only the information that a reasonable physician in the same or similar medical specialty would know and disclose under the circumstances. As a result of the legislation doctors must obtain informed consent from their patients by advising them of reasonable alternate medical modes of treatment and the benefits and risks of those treatments in a manner consistent with the reasonable physician standard. The proposed rule will update Wis. Admin. Code s. Med 18 to reflect these changes.

10. Summary of the businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule that were contacted for comments.

The Rule was posted on the Department and Professional Services website for 14 days in order to solicit comments from businesses, associations representing of Safety businesses, local governmental units and individuals that may be affected by the rule. No comments were received.

11. Identify the local governmental units that participated in the development of this EIA.

No local governmental units participated in the development of this EIA.

12. Summary of Rule's Economic and Fiscal Impact on Specific Businesses, Business Sectors, Public Utility Rate Payers, Local Governmental Units and the State's Economy as a Whole (Include Implementation and Compliance Costs Expected to be Incurred)

This proposed rule will not have a significant impact on specific businesses, business sectors, public utility rate payers, local governmental units or the state's economy as a whole.

13. Benefits of Implementing the Rule and Alternative(s) to Implementing the Rule

Physicians will advise their patients their patients in a manner of alternate modes of treatment in a manner that is consistent with current law. There is no alternative to implementing the proposed rule due to the changes being necessitated by passage of legislation.

## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

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14. Long Range Implications of Implementing the Rule

Physicians consistently advising patients of reasonable alternate medical modes of treatment will result in physicians upholding their duty to inform patients in accordance with s. 448.30, Stats.

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15. Compare With Approaches Being Used by Federal Government

Several federal agencies, including but not limited to the Food and Drug Administration, have rules protecting human subjects participating in investigative trials. Investigators are required to obtain informed consent of each person that will participate in experimental studies, 21 CFR 50.20, including experiments involving drugs for human use found in 21 CFR 312.60. Obtaining informed consent from participants in the investigatory research is not intended to preempt any applicable federal, state, or local laws which require additional information to be disclosed in order for informed consent to be legally effective.

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16. Compare With Approaches Being Used by Neighboring States (Illinois, Iowa, Michigan and Minnesota)

**Illinois:** Illinois does not have a comparable statute or rule.

**Iowa:** Iowa statutes create a presumption that informed consent was given if it is documented in writing. "A consent in writing to any medical or surgical procedure or course of procedure in patient care which meets the requirements of this section shall create a presumption that informed consent was given." IOWA CODE § 147.137.

**Michigan:** Michigan's statute has comparable language which is directed towards physicians who are treating breast cancer patients. Physicians are required to inform patients verbally and in writing about alternative modes of treatment of cancer. The statute sets forth the reasonable physician standards. "A physician's duty to inform a patient under this section does not require disclosure of information beyond what a reasonably well-qualified physician licensed under this article would know." MCLS §333.17013 (6).

**Minnesota:** Minnesota does not have comparable statute or rule.

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17. Contact Name

Katie Paff

18. Contact Phone Number

608-261-4472

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This document can be made available in alternate formats to individuals with disabilities upon request.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  Taylor Thompson, Bureau Assistant on behalf of Tom Ryan, Executive Director		2) Date When Request Submitted:  4/28/15 Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections:  Medical Examining Board			
4) Meeting Date:  5/20/15	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  LRB-1138/1 Relating to Ratification of the Interstate Medical Licensure Compact	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:			
11) Authorization			
<b>Taylor Thompson</b> Signature of person making this request		<b>4/28/15</b> Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

## CO-SPONSORSHIP MEMORANDUM

**TO:** All Legislators

**FROM:** Senator Harsdorf & Representative VanderMeer

**DATE:** April 27, 2015

**RE:** Co-Sponsorship of LRB-1138/1 relating to ratification of the Interstate Medical Licensure Compact

**DEADLINE: 12:00 PM Friday, May 8, 2015**

LRB 1138/1, the **Interstate Physician Licensure Compact Implementation Bill**, is legislation that cuts regulatory red tape and provides efficiencies for state government and license holders all while increasing access to health care in Wisconsin. This is accomplished by creating a more expedient process for physicians to receive a medical license in Wisconsin and other states that join the Interstate Physician Licensure Compact. The Compact is supported by a coalition of health care systems, the Wisconsin Hospital Association, the Wisconsin Medical Society, and others, along with the Wisconsin Medical Examining Board.

Under current law, when a physician in another state wishes to practice in Wisconsin, that physician must apply for and receive a medical license in Wisconsin. Even for physicians with a clean practice record, it can take 3 to 6 months or more to gather and process all of the paperwork for a physician to receive a Wisconsin license. The Wisconsin Department of Safety Professional Services has indicated that, at times, this delay is caused by the lag of verification information provided by other states.

By enacting the Interstate Physician Licensure Compact, Wisconsin will join with other Compact states to create a common, multi-state expedited physician licensure process for physicians with a clean practice record, so that such physicians can begin providing care to Wisconsin communities much more quickly.

**Importantly, a physician's participation in the Interstate Physician Licensure Compact is voluntary.** Physicians that choose not to use the Compact process or that are ineligible for the Compact process may continue to seek licensure in Wisconsin and other Compact states under the current licensure process. Further, the Compact explicitly does not alter a state's practice act; each state that joins the Compact continues to have sole authority to govern the practice of physicians practicing within the state. Finally, the implementation portion of the bill has been written with the intent that any additional costs incurred by Wisconsin to participate in the Compact would be borne by those physicians that choose to utilize the Compact licensure process.

Since being introduced nationally in Fall of 2014, the Compact has been enacted in Wyoming, South Dakota, Utah, Idaho, West Virginia, and Montana as of April 20, and is advancing in several other states including Illinois and Minnesota.

**A bill draft is also attached. If you would like to co-sponsor this legislation and its Senate companion, please contact Rep. VanderMeer's office at 6-8366 or Senator Harsdorf's office at 6-7745 by Friday, May 8, at 12:00 p.m.**

*Analysis by the Legislative Reference Bureau*

This bill ratifies and enters Wisconsin into the Interstate Medical Licensure Compact (compact), which provides for, as stated in the compact, "a streamlined process that allows physicians to become licensed in multiple states." Provisions in the compact are to be administered by boards that regulate physicians in the states that are parties to the compact (member boards). Significant provisions of the compact include:

1. The creation of an Interstate Medical Licensure Compact Commission (commission), which includes two representatives of each member board. The commission has various powers and duties granted in the compact, including overseeing the administration of the compact, enforcing the compact, adopting bylaws, promulgating binding rules for the compact, employing an executive director and employees, and maintaining records.
2. A process whereby a physician who possesses a license to engage in the practice of medicine issued by a member board and who satisfies other criteria designates a state where the physician is already licensed as his or her state of principal license and applies to the member board in that state for licensure through the compact. After a verification and registration process that includes a background check, the physician may receive an "expedited license" in other states that are parties to the compact. If a physician's license in his or her state of principal license is revoked or suspended, then all expedited licenses issued by other states are revoked or suspended as well until each is reinstated.
3. The ability for member boards to conduct joint investigations of physicians and the ability of member states to issue subpoenas that are enforceable in other states.
4. The creation of a coordinated information system including a database of all physicians who have applied for or received an expedited license. The compact requires, or in other cases allows, for member boards to submit public actions, complaints, or disciplinary information to the commission.

The compact provides that it becomes effective upon being enacted into law by seven states and that it may be amended upon enactment of an amendment by all member states. A state may withdraw from the compact by repealing the statute authorizing the compact, but the compact provides that a withdrawal does not take effect until one year after the effective date of that repeal.

The compact provides that laws of a member state that are not inconsistent with the compact may be enforced, but that all laws of a member state in conflict with the compact are superseded to the extent of the conflict.

In addition to enacting the compact, the bill provides all of the following:

1. Numerous limitations on the sharing of information under the compact about physicians, including limiting disclosures to physicians who have designated or applied to designate this state as their state of principal license or who hold or are applying to hold expedited licenses granted by the Wisconsin Medical Examining Board (MEB). The bill also includes limitations with respect to the enforceability of subpoenas under the compact and investigations of other states' medical practice laws.
2. A requirement that the Wisconsin MEB report annually to the Joint Committee on Finance about investigations of physicians under the compact.
3. That payment of this state's assessments under the commission is from licensure fees paid by physicians who have applied for licensure through the compact.



## 2015 BILL

1     **AN ACT** *to renumber and amend* 440.03 (11m) (c); *to amend* 20.165 (1) (hg),  
2           440.03 (13) (b) (intro.), 440.03 (13) (d), 440.05 (intro.), 440.08 (2) (c), 440.14 (2),  
3           440.14 (3), 440.15, 448.01 (5), 448.05 (2) (a) (intro.), 448.05 (2) (b) (intro.), 448.07  
4           (1) (a) and 448.07 (2); and *to create* 14.83, 440.03 (11m) (c) 2., 440.08 (2) (e),  
5           448.015 (1dm), 448.04 (1) (ab), 448.05 (2) (f) and subchapter VIII of chapter 448  
6           [precedes 448.980] of the statutes; **relating to:** ratification of the Interstate  
7           Medical Licensure Compact and making appropriations.

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### *Analysis by the Legislative Reference Bureau*

This bill ratifies and enters Wisconsin into the Interstate Medical Licensure Compact (compact), which provides for, as stated in the compact, “a streamlined process that allows physicians to become licensed in multiple states.” Provisions in the compact are to be administered by boards that regulate physicians in the states that are parties to the compact (member boards). Significant provisions of the compact include:

1. The creation of an Interstate Medical Licensure Compact Commission (commission), which includes two representatives of each member board. The commission has various powers and duties granted in the compact, including overseeing the administration of the compact, enforcing the compact, adopting bylaws, promulgating binding rules for the compact, employing an executive director and employees, and maintaining records.

**BILL**

2. A process whereby a physician who possesses a license to engage in the practice of medicine issued by a member board and who satisfies other criteria designates a state where the physician is already licensed as his or her state of principal license and applies to the member board in that state for licensure through the compact. After a verification and registration process that includes a background check, the physician may receive an “expedited license” in other states that are parties to the compact. If a physician’s license in his or her state of principal license is revoked or suspended, then all expedited licenses issued by other states are revoked or suspended as well until each is reinstated.

3. The ability for member boards to conduct joint investigations of physicians and the ability of member states to issue subpoenas that are enforceable in other states.

4. The creation of a coordinated information system including a database of all physicians who have applied for or received an expedited license. The compact requires, or in other cases allows, for member boards to submit public actions, complaints, or disciplinary information to the commission.

The compact provides that it becomes effective upon being enacted into law by seven states and that it may be amended upon enactment of an amendment by all member states. A state may withdraw from the compact by repealing the statute authorizing the compact, but the compact provides that a withdrawal does not take effect until one year after the effective date of that repeal.

The compact provides that laws of a member state that are not inconsistent with the compact may be enforced, but that all laws of a member state in conflict with the compact are superseded to the extent of the conflict.

In addition to enacting the compact, the bill provides all of the following:

1. Numerous limitations on the sharing of information under the compact about physicians, including limiting disclosures to physicians who have designated or applied to designate this state as their state of principal license or who hold or are applying to hold expedited licenses granted by the Wisconsin Medical Examining Board (MEB). The bill also includes limitations with respect to the enforceability of subpoenas under the compact and investigations of other states’ medical practice laws.

2. A requirement that the Wisconsin MEB report annually to the Joint Committee on Finance about investigations of physicians under the compact.

3. That payment of this state’s assessments under the commission is from licensure fees paid by physicians who have applied for licensure through the compact.

For further information see the *state* fiscal estimate, which will be printed as an appendix to this bill.

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***The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:***

1           **SECTION 1.** 14.83 of the statutes is created to read:

**BILL**

1           **14.83 Interstate medical licensure compact.** There is created an  
2 interstate medical licensure compact commission as specified in s. 448.980. The  
3 members of the commission representing this state under s. 448.980 (11) (d) shall be  
4 members of the medical examining board and shall be appointed by the chairperson  
5 of the medical examining board. The commission has the powers and duties granted  
6 and imposed under s. 448.980.

7           **SECTION 2.** 20.165 (1) (hg) of the statutes is amended to read:

8           20.165 (1) (hg) *General program operations; medical examining board;*  
9 *interstate medical licensure compact; prescription drug monitoring program.*  
10 Biennially, the amounts in the schedule for the licensing, rule-making, and  
11 regulatory functions of the medical examining board and the affiliated credentialing  
12 boards attached to the medical examining board, except for preparing,  
13 administering, and grading examinations; for any costs associated with the  
14 interstate medical licensure compact under s. 448.980, including payment of  
15 assessments under s. 448.980 (13) (a); and for the pharmacy examining board's  
16 operation of the prescription drug monitoring program under s. 450.19. Ninety  
17 percent of all moneys received for issuing and renewing credentials under ch. 448  
18 shall be credited to this appropriation. All moneys received from the interstate  
19 medical licensure compact commission under s. 448.980 shall be credited to this  
20 appropriation.

21           **SECTION 3.** 440.03 (11m) (c) of the statutes is renumbered 440.03 (11m) (c)  
22 (intro.) and amended to read:

23           440.03 (11m) (c) (intro.) The department of safety and professional services  
24 may not disclose a social security number obtained under par. (a) to any person  
25 except for the following:

**BILL**

1           1. The coordinated licensure information system under s. 441.50 (7); the.

2           3. The department of children and families for purposes of administering s.  
3           49.22; and, for.

4           4. For a social security number obtained under par. (a) 1., the department of  
5           revenue for the purpose of requesting certifications under s. 73.0301 and  
6           administering state taxes and the department of workforce development for the  
7           purpose of requesting certifications under s. 108.227.

8           **SECTION 4.** 440.03 (11m) (c) 2. of the statutes is created to read:

9           440.03 (11m) (c) 2. The coordinated licensure information system under s.  
10           448.980 (8), if such disclosure is required under the interstate medical licensure  
11           compact under s. 448.980.

12           **SECTION 5.** 440.03 (13) (b) (intro.) of the statutes is amended to read:

13           440.03 (13) (b) (intro.) The department may investigate whether an applicant  
14           for or holder of any of the following credentials has been charged with or convicted  
15           of a crime only pursuant to rules promulgated by the department under this  
16           paragraph, including rules that establish the criteria that the department will use  
17           to determine whether an investigation under this paragraph is necessary, except as  
18           provided in par. (c) and s. 448.980 (5) (b) 3.:

19           **SECTION 6.** 440.03 (13) (d) of the statutes is amended to read:

20           440.03 (13) (d) The department shall charge an applicant any fees, costs, or  
21           other expenses incurred in conducting any investigation under this subsection or s.  
22           440.26. The department shall charge an applicant seeking licensure through the  
23           interstate medical licensure compact under s. 448.980, directly or indirectly, for any  
24           expenses incurred in conducting any investigation under s. 448.980 (5) (b) 3.

25           **SECTION 7.** 440.05 (intro.) of the statutes is amended to read:

**BILL**

1           **440.05 Standard fees.** (intro.) The following standard fees apply to all initial  
2           credentials, except as provided in ss. 440.51, 444.03, 444.11, 446.02 (2) (c), 447.04 (2)  
3           (c) 2., 448.07 (2), 449.17 (1m) (d), and 449.18 (2) (d):

4           **SECTION 8.** 440.08 (2) (c) of the statutes is amended to read:

5           440.08 (2) (c) Except as provided in par. (e) and sub. (3), renewal applications  
6           shall include the applicable renewal fee as determined by the department under s.  
7           440.03 (9) (a) or as specified in par. (b).

8           **SECTION 9.** 440.08 (2) (e) of the statutes is created to read:

9           440.08 (2) (e) A renewal of a compact license, as defined in s. 448.015 (1dm),  
10          shall be governed by s. 448.980 (7) and is subject to s. 448.07 (2).

11          **SECTION 10.** 440.14 (2) of the statutes is amended to read:

12          440.14 (2) If a form that the department or a credentialing board requires an  
13          individual to complete in order to apply for a credential or credential renewal or to  
14          obtain a product or service from the department or the credentialing board requires  
15          the individual to provide any of the individual's personal identifiers, the form shall  
16          include a place for the individual to declare that the individual's personal identifiers  
17          obtained by the department or the credentialing board from the information on the  
18          form may not be disclosed on any list that the department or the credentialing board  
19          furnishes to another person. This subsection does not apply with respect to an  
20          application filed with the medical examining board pursuant to the interstate  
21          medical licensure compact under s. 448.980 (5).

22          **SECTION 11.** 440.14 (3) of the statutes is amended to read:

23          440.14 (3) If the department or a credentialing board requires an individual  
24          to provide, by telephone or other electronic means, any of the individual's personal  
25          identifiers in order to apply for a credential or credential renewal or to obtain a

**BILL**

1 product or service from the department or a credentialing board, the department or  
2 the credentialing board shall ask the individual at the time that the individual  
3 provides the information if the individual wants to declare that the individual's  
4 personal identifiers obtained by telephone or other electronic means may not be  
5 disclosed on any list that the department or the credentialing board furnishes to  
6 another person. This subsection does not apply with respect to an application filed  
7 with the medical examining board pursuant to the interstate medical licensure  
8 compact under s. 448.980 (5).

9 **SECTION 12.** 440.15 of the statutes is amended to read:

10 **440.15 No fingerprinting.** Except as provided under s. ss. 440.03 (13) (c) and  
11 448.980 (5) (b) 3., the department or a credentialing board may not require that an  
12 applicant for a credential or a credential holder be fingerprinted or submit  
13 fingerprints in connection with the department's or the credentialing board's  
14 credentialing.

15 **SECTION 13.** 448.01 (5) of the statutes is amended to read:

16 448.01 (5) "Physician" means an individual possessing the degree of doctor of  
17 medicine or doctor of osteopathy or an equivalent degree as determined by the  
18 medical examining board, and holding a license granted by the medical examining  
19 board. This subsection does not apply in s. 448.980.

20 **SECTION 14.** 448.015 (1dm) of the statutes is created to read:

21 448.015 (1dm) "Compact license" means an expedited license granted by the  
22 board pursuant to the interstate medical licensure compact under s. 448.980.

23 **SECTION 15.** 448.04 (1) (ab) of the statutes is created to read:

24 448.04 (1) (ab) *Compact license.* The board may grant a compact license  
25 pursuant to the interstate medical licensure compact under s. 448.980.

**BILL**

1           **SECTION 16.** 448.05 (2) (a) (intro.) of the statutes, as affected by 2013 Wisconsin  
2 Act 240, is amended to read:

3           448.05 (2) (a) (intro.) Except as provided in pars. (b) to ~~(e)~~ (f), an applicant for  
4 any class of license to practice medicine and surgery must supply evidence  
5 satisfactory to the board of all of the following:

6           **SECTION 17.** 448.05 (2) (b) (intro.) of the statutes, as affected by 2013 Wisconsin  
7 Act 240, is amended to read:

8           448.05 (2) (b) (intro.) Except as provided in pars. (c) to ~~(e)~~ (f), an applicant for  
9 a license to practice medicine and surgery who is a graduate of a foreign medical  
10 college must supply evidence satisfactory to the board of all of the following:

11           **SECTION 18.** 448.05 (2) (f) of the statutes is created to read:

12           448.05 (2) (f) The board shall grant a compact license as provided under s.  
13 448.980.

14           **SECTION 19.** 448.07 (1) (a) of the statutes is amended to read:

15           448.07 (1) (a) Every person licensed or certified under this subchapter shall  
16 register on or before November 1 of each odd-numbered year following issuance of  
17 the license or certificate with the board. Registration shall be completed in such  
18 manner as the board shall designate and upon forms the board shall provide, except  
19 that registration with respect to a compact license shall be governed by the renewal  
20 provisions in s. 448.980 (7). The secretary of the board, on or before October 1 of each  
21 odd-numbered year, shall mail or cause to be mailed to every person required to  
22 register a registration form. The board shall furnish to each person registered under  
23 this section a certificate of registration, and the person shall display the registration  
24 certificate conspicuously in the office at all times. No person may exercise the rights

**BILL**

1 or privileges conferred by any license or certificate granted by the board unless  
2 currently registered as required under this subsection.

3 **SECTION 20.** 448.07 (2) of the statutes is amended to read:

4 448.07 (2) FEES. The Except as otherwise provided in s. 448.980, the fees for  
5 examination and licenses granted under this subchapter are specified in s. 440.05,  
6 and the renewal fee for such licenses is determined by the department under s.  
7 440.03 (9) (a). Compact licenses shall be subject to additional fees and assessments,  
8 as established by the department, the board, or the interstate medical licensure  
9 compact commission, to cover any costs incurred by the department or the board for  
10 this state's participation in the interstate medical licensure compact under s.  
11 448.980 and costs incurred by the interstate medical licensure compact commission  
12 for its administration of the renewal process for the interstate medical licensure  
13 compact under s. 448.980.

14 **SECTION 21.** Subchapter VIII of chapter 448 [precedes 448.980] of the statutes  
15 is created to read:

**CHAPTER 448****SUBCHAPTER VIII****INTERSTATE MEDICAL LICENSURE****COMPACT**

16  
17  
18  
19  
20 **448.980 Interstate medical licensure compact.** The following compact is  
21 hereby ratified and entered into:

22 (1) SECTION 1 — PURPOSE. In order to strengthen access to health care, and in  
23 recognition of the advances in the delivery of health care, the member states of the  
24 interstate medical licensure compact have allied in common purpose to develop a  
25 comprehensive process that complements the existing licensing and regulatory

**BILL**

1 authority of state medical boards, provides a streamlined process that allows  
2 physicians to become licensed in multiple states, thereby enhancing the portability  
3 of a medical license and ensuring the safety of patients. The compact creates another  
4 pathway for licensure and does not otherwise change a state’s existing medical  
5 practice act. The compact also adopts the prevailing standard for licensure and  
6 affirms that the practice of medicine occurs where the patient is located at the time  
7 of the physician–patient encounter, and therefore, requires the physician to be under  
8 the jurisdiction of the state medical board where the patient is located. State medical  
9 boards that participate in the compact retain the jurisdiction to impose an adverse  
10 action against a license to practice medicine in that state issued to a physician  
11 through the procedures in the compact.

12 (2) SECTION 2 – DEFINITIONS. In this compact:

13 (a) “Bylaws” means those bylaws established by the interstate commission  
14 pursuant to sub. (11) for its governance, or for directing and controlling its actions  
15 and conduct.

16 (b) “Commissioner” means the voting representative appointed by each  
17 member board pursuant to sub. (11).

18 (c) “Conviction” means a finding by a court that an individual is guilty of a  
19 criminal offense through adjudication, or entry of a plea of guilt or no contest to the  
20 charge by the offender. Evidence of an entry of a conviction of a criminal offense by  
21 the court shall be considered final for purposes of disciplinary action by a member  
22 board.

23 (d) “Expedited license” means a full and unrestricted medical license granted  
24 by a member state to an eligible physician through the process set forth in the  
25 compact.

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1 (e) “Interstate commission” means the interstate commission created pursuant  
2 to sub. (11).

3 (f) “License” means authorization by a state for a physician to engage in the  
4 practice of medicine, which would be unlawful without the authorization.

5 (g) “Medical practice act” means laws and regulations governing the practice  
6 of allopathic and osteopathic medicine within a member state.

7 (h) “Member board” means a state agency in a member state that acts in the  
8 sovereign interests of the state by protecting the public through licensure,  
9 regulation, and education of physicians as directed by the state government.

10 (i) “Member state” means a state that has enacted the compact.

11 (j) “Practice of medicine” means the clinical prevention, diagnosis, or treatment  
12 of human disease, injury, or condition requiring a physician to obtain and maintain  
13 a license in compliance with the medical practice act of a member state.

14 (k) “Physician” means any person who:

15 1. Is a graduate of a medical school accredited by the Liaison Committee on  
16 Medical Education, the Commission on Osteopathic College Accreditation, or a  
17 medical school listed in the International Medical Education Directory or its  
18 equivalent;

19 2. Passed each component of the United States Medical Licensing Examination  
20 (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination  
21 (COMLEX–USA) within 3 attempts, or any of its predecessor examinations accepted  
22 by a state medical board as an equivalent examination for licensure purposes;

23 3. Successfully completed graduate medical education approved by the  
24 Accreditation Council for Graduate Medical Education or the American Osteopathic  
25 Association;

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1           4. Holds specialty certification or a time-unlimited specialty certificate  
2 recognized by the American Board of Medical Specialties or the American  
3 Osteopathic Association’s Bureau of Osteopathic Specialists;

4           5. Possesses a full and unrestricted license to engage in the practice of medicine  
5 issued by a member board;

6           6. Has never been convicted, received adjudication, deferred adjudication,  
7 community supervision, or deferred disposition for any offense by a court of  
8 appropriate jurisdiction;

9           7. Has never held a license authorizing the practice of medicine subjected to  
10 discipline by a licensing agency in any state, federal, or foreign jurisdiction,  
11 excluding any action related to non-payment of fees related to a license;

12           8. Has never had a controlled substance license or permit suspended or revoked  
13 by a state or the united states drug enforcement administration; and

14           9. Is not under active investigation by a licensing agency or law enforcement  
15 authority in any state, federal, or foreign jurisdiction.

16           (L) “Offense” means a felony, gross misdemeanor, or crime of moral turpitude.

17           (m) “Rule” means a written statement by the interstate commission  
18 promulgated pursuant to sub. (12) that is of general applicability, implements,  
19 interprets, or prescribes a policy or provision of the compact, or an organizational,  
20 procedural, or practice requirement of the interstate commission, and has the force  
21 and effect of statutory law in a member state, and includes the amendment, repeal,  
22 or suspension of an existing rule.

23           (n) “State” means any state, commonwealth, district, or territory of the United  
24 States.

**BILL**

1 (o) “State of principal license” means a member state where a physician holds  
2 a license to practice medicine and which has been designated as such by the  
3 physician for purposes of registration and participation in the compact.

4 (3) SECTION 3 — ELIGIBILITY. (a) A physician must meet the eligibility  
5 requirements as defined in sub. (2) (k) to receive an expedited license under the terms  
6 and provisions of the compact.

7 (b) A physician who does not meet the requirements of sub. (2) (k) may obtain  
8 a license to practice medicine in a member state if the individual complies with all  
9 laws and requirements, other than the compact, relating to the issuance of a license  
10 to practice medicine in that state.

11 (4) SECTION 4 — DESIGNATION OF STATE OF PRINCIPAL LICENSE. (a) A physician shall  
12 designate a member state as the state of principal license for purposes of registration  
13 for expedited licensure through the compact if the physician possesses a full and  
14 unrestricted license to practice medicine in that state, and the state is:

- 15 1. The state of primary residence for the physician; or
- 16 2. The state where at least 25% of the practice of medicine occurs, or
- 17 3. The location of the physician’s employer; or
- 18 4. If no state qualifies under subd. 1., 2., or 3., the state designated as state of  
19 residence for purpose of federal income tax.

20 (b) A physician may redesignate a member state as state of principal license  
21 at any time, as long as the state meets the requirements in par. (a).

22 (c) The interstate commission is authorized to develop rules to facilitate  
23 redesignation of another member state as the state of principal license.

24 (5) SECTION 5 — APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE. (a) A  
25 physician seeking licensure through the compact shall file an application for an

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1 expedited license with the member board of the state selected by the physician as the  
2 state of principal license.

3 (b) 1. Upon receipt of an application for an expedited license, the member board  
4 within the state selected as the state of principal license shall evaluate whether the  
5 physician is eligible for expedited licensure and issue a letter of qualification,  
6 verifying or denying the physician's eligibility, to the interstate commission.

7 2. Static qualifications, which include verification of medical education,  
8 graduate medical education, results of any medical or licensing examination, and  
9 other qualifications as determined by the interstate commission through rule, shall  
10 not be subject to additional primary source verification where already primary  
11 source verified by the state of principal license.

12 3. The member board within the state selected as the state of principal license  
13 shall, in the course of verifying eligibility, perform a criminal background check of  
14 an applicant, including the use of the results of fingerprint or other biometric data  
15 checks compliant with the requirements of the federal bureau of investigation, with  
16 the exception of federal employees who have suitability determination in accordance  
17 with 5 CFR 731.202.

18 4. Appeal on the determination of eligibility shall be made to the member state  
19 where the application was filed and shall be subject to the law of that state.

20 (c) Upon verification in par. (b), physicians eligible for an expedited license  
21 shall complete the registration process established by the interstate commission to  
22 receive a license in a member state selected pursuant to par. (a), including the  
23 payment of any applicable fees.

24 (d) After receiving verification of eligibility under par. (b) and any fees under  
25 par. (c), a member board shall issue an expedited license to the physician. This

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1 license shall authorize the physician to practice medicine in the issuing state  
2 consistent with the medical practice act and all applicable laws and regulations of  
3 the issuing member board and member state.

4 (e) An expedited license shall be valid for a period consistent with the licensure  
5 period in the member state and in the same manner as required for other physicians  
6 holding a full and unrestricted license within the member state.

7 (f) An expedited license obtained through the compact shall be terminated if a  
8 physician fails to maintain a license in the state of principal licensure for a  
9 non-disciplinary reason, without redesignation of a new state of principal licensure.

10 (g) The interstate commission is authorized to develop rules regarding the  
11 application process, including payment of any applicable fees, and the issuance of an  
12 expedited license.

13 **(6) SECTION 6 — FEES FOR EXPEDITED LICENSURE.** (a) A member state issuing an  
14 expedited license authorizing the practice of medicine in that state may impose a fee  
15 for a license issued or renewed through the compact.

16 (b) The interstate commission is authorized to develop rules regarding fees for  
17 expedited licenses.

18 **(7) SECTION 7 — RENEWAL AND CONTINUED PARTICIPATION.** (a) A physician seeking  
19 to renew an expedited license granted in a member state shall complete a renewal  
20 process with the interstate commission if the physician:

- 21 1. Maintains a full and unrestricted license in a state of principal license;
- 22 2. Has not been convicted, received adjudication, deferred adjudication,  
23 community supervision, or deferred disposition for any offense by a court of  
24 appropriate jurisdiction;

**BILL**

1           3. Has not had a license authorizing the practice of medicine subject to  
2 discipline by a licensing agency in any state, federal, or foreign jurisdiction,  
3 excluding any action related to non-payment of fees related to a license; and

4           4. Has not had a controlled substance license or permit suspended or revoked  
5 by a state or the united states drug enforcement administration.

6           (b) Physicians shall comply with all continuing professional development or  
7 continuing medical education requirements for renewal of a license issued by a  
8 member state.

9           (c) The interstate commission shall collect any renewal fees charged for the  
10 renewal of a license and distribute the fees to the applicable member board.

11           (d) Upon receipt of any renewal fees collected in par. (c), a member board shall  
12 renew the physician's license.

13           (e) Physician information collected by the interstate commission during the  
14 renewal process will be distributed to all member boards.

15           (f) The interstate commission is authorized to develop rules to address renewal  
16 of licenses obtained through the compact.

17           **(8) SECTION 8 — COORDINATED INFORMATION SYSTEM.** (a) The interstate  
18 commission shall establish a database of all physicians licensed, or who have applied  
19 for licensure, under sub. (5).

20           (b) Notwithstanding any other provision of law, member boards shall report to  
21 the interstate commission any public action or complaints against a licensed  
22 physician who has applied or received an expedited license through the compact.

23           (c) Member boards shall report disciplinary or investigatory information  
24 determined as necessary and proper by rule of the interstate commission.

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1 (d) Member boards may report any non-public complaint, disciplinary, or  
2 investigatory information not required by par. (c) to the interstate commission.

3 (e) Member boards shall share complaint or disciplinary information about a  
4 physician upon request of another member board.

5 (f) All information provided to the interstate commission or distributed by  
6 member boards shall be confidential, filed under seal, and used only for investigatory  
7 or disciplinary matters.

8 (g) The interstate commission is authorized to develop rules for mandated or  
9 discretionary sharing of information by member boards.

10 **(9) SECTION 9 — JOINT INVESTIGATIONS.** (a) Licensure and disciplinary records  
11 of physicians are deemed investigative.

12 (b) In addition to the authority granted to a member board by its respective  
13 medical practice act or other applicable state law, a member board may participate  
14 with other member boards in joint investigations of physicians licensed by the  
15 member boards.

16 (c) A subpoena issued by a member state shall be enforceable in other member  
17 states.

18 (d) Member boards may share any investigative, litigation, or compliance  
19 materials in furtherance of any joint or individual investigation initiated under the  
20 compact.

21 (e) Any member state may investigate actual or alleged violations of the  
22 statutes authorizing the practice of medicine in any other member state in which a  
23 physician holds a license to practice medicine.

24 **(10) SECTION 10 — DISCIPLINARY ACTIONS.** (a) Any disciplinary action taken by  
25 any member board against a physician licensed through the compact shall be deemed

**BILL**

1 unprofessional conduct which may be subject to discipline by other member boards,  
2 in addition to any violation of the medical practice act or regulations in that state.

3 (b) If a license granted to a physician by the member board in the state of  
4 principal license is revoked, surrendered or relinquished in lieu of discipline, or  
5 suspended, then all licenses issued to the physician by member boards shall  
6 automatically be placed, without further action necessary by any member board, on  
7 the same status. If the member board in the state of principal license subsequently  
8 reinstates the physician's license, a license issued to the physician by any other  
9 member board shall remain encumbered until that respective member board takes  
10 action to reinstate the license in a manner consistent with the medical practice act  
11 of that state.

12 (c) If disciplinary action is taken against a physician by a member board not  
13 in the state of principal license, any other member board may deem the action  
14 conclusive as to matter of law and fact decided, and:

15 1. Impose the same or lesser sanctions against the physician so long as such  
16 sanctions are consistent with the medical practice act of that state; or

17 2. Pursue separate disciplinary action against the physician under its  
18 respective medical practice act, regardless of the action taken in other member  
19 states.

20 (d) If a license granted to a physician by a member board is revoked,  
21 surrendered or relinquished in lieu of discipline, or suspended, then any license  
22 issued to the physician by any other member board shall be suspended,  
23 automatically and immediately without further action necessary by the other  
24 member board, for 90 days upon entry of the order by the disciplining board, to permit  
25 the member board to investigate the basis for the action under the medical practice

**BILL**

1 act of that state. A member board may terminate the automatic suspension of the  
2 license it issued prior to the completion of the 90 day suspension period in a manner  
3 consistent with the medical practice act of that state.

4 (11) SECTION 11 — INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION. (a) The  
5 member states hereby create the “Interstate Medical Licensure Compact  
6 Commission.”

7 (b) The purpose of the interstate commission is the administration of the  
8 interstate medical licensure compact, which is a discretionary state function.

9 (c) The interstate commission shall be a body corporate and joint agency of the  
10 member states and shall have all the responsibilities, powers, and duties set forth  
11 in the compact, and such additional powers as may be conferred upon it by a  
12 subsequent concurrent action of the respective legislatures of the member states in  
13 accordance with the terms of the compact.

14 (d) The interstate commission shall consist of 2 voting representatives  
15 appointed by each member state who shall serve as commissioners. In states where  
16 allopathic and osteopathic physicians are regulated by separate member boards, or  
17 if the licensing and disciplinary authority is split between multiple member boards  
18 within a member state, the member state shall appoint one representative from each  
19 member board. A Commissioner shall be:

- 20 1. An allopathic or osteopathic physician appointed to a member board;
- 21 2. An executive director, executive secretary, or similar executive of a member  
22 board; or
- 23 3. A member of the public appointed to a member board.

24 (e) The interstate commission shall meet at least once each calendar year. A  
25 portion of this meeting shall be a business meeting to address such matters as may

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1 properly come before the commission, including the election of officers. The  
2 chairperson may call additional meetings and shall call for a meeting upon the  
3 request of a majority of the member states.

4 (f) The bylaws may provide for meetings of the interstate commission to be  
5 conducted by telecommunication or electronic communication.

6 (g) Each commissioner participating at a meeting of the interstate commission  
7 is entitled to one vote. A majority of commissioners shall constitute a quorum for the  
8 transaction of business, unless a larger quorum is required by the bylaws of the  
9 interstate commission. A commissioner shall not delegate a vote to another  
10 commissioner. In the absence of its commissioner, a member state may delegate  
11 voting authority for a specified meeting to another person from that state who shall  
12 meet the requirements of par. (d).

13 (h) The interstate commission shall provide public notice of all meetings and  
14 all meetings shall be open to the public. The interstate commission may close a  
15 meeting, in full or in portion, where it determines by a two-thirds vote of the  
16 commissioners present that an open meeting would be likely to:

17 1. Relate solely to the internal personnel practices and procedures of the  
18 interstate commission;

19 2. Discuss matters specifically exempted from disclosure by federal statute;

20 3. Discuss trade secrets, commercial, or financial information that is privileged  
21 or confidential;

22 4. Involve accusing a person of a crime, or formally censuring a person;

23 5. Discuss information of a personal nature where disclosure would constitute  
24 a clearly unwarranted invasion of personal privacy;

25 6. Discuss investigative records compiled for law enforcement purposes; or

**BILL**

1           7. Specifically relate to the participation in a civil action or other legal  
2 proceeding.

3           (i) The interstate commission shall keep minutes which shall fully describe all  
4 matters discussed in a meeting and shall provide a full and accurate summary of  
5 actions taken, including record of any roll call votes.

6           (j) The interstate commission shall make its information and official records,  
7 to the extent not otherwise designated in the compact or by its rules, available to the  
8 public for inspection.

9           (k) The interstate commission shall establish an executive committee, which  
10 shall include officers, members, and others as determined by the bylaws. The  
11 executive committee shall have the power to act on behalf of the interstate  
12 commission, with the exception of rule making, during periods when the interstate  
13 commission is not in session. When acting on behalf of the interstate commission,  
14 the executive committee shall oversee the administration of the compact including  
15 enforcement and compliance with the provisions of the compact, its bylaws and rules,  
16 and other such duties as necessary.

17           (L) The Interstate commission may establish other committees for governance  
18 and administration of the compact.

19           **(12)** SECTION 12 — POWERS AND DUTIES OF THE INTERSTATE COMMISSION. The  
20 interstate commission shall have the duty and power to:

21           (a) Oversee and maintain the administration of the compact;

22           (b) Promulgate rules which shall be binding to the extent and in the manner  
23 provided for in the compact;

**BILL**

1 (c) Issue, upon the request of a member state or member board, advisory  
2 opinions concerning the meaning or interpretation of the compact, its bylaws, rules,  
3 and actions;

4 (d) Enforce compliance with compact provisions, the rules promulgated by the  
5 interstate commission, and the bylaws, using all necessary and proper means,  
6 including but not limited to the use of judicial process;

7 (e) Establish and appoint committees including, but not limited to, an executive  
8 committee as required by sub. (11), which shall have the power to act on behalf of the  
9 interstate commission in carrying out its powers and duties;

10 (f) Pay, or provide for the payment of the expenses related to the establishment,  
11 organization, and ongoing activities of the interstate commission;

12 (g) Establish and maintain one or more offices;

13 (h) Borrow, accept, hire, or contract for services of personnel;

14 (i) Purchase and maintain insurance and bonds;

15 (j) Employ an executive director who shall have such powers to employ, select  
16 or appoint employees, agents, or consultants, and to determine their qualifications,  
17 define their duties, and fix their compensation;

18 (k) Establish personnel policies and programs relating to conflicts of interest,  
19 rates of compensation, and qualifications of personnel;

20 (L) Accept donations and grants of money, equipment, supplies, materials and  
21 services, and to receive, utilize, and dispose of it in a manner consistent with the  
22 conflict of interest policies established by the interstate commission;

23 (m) Lease, purchase, accept contributions or donations of, or otherwise to own,  
24 hold, improve or use, any property, real, personal, or mixed;

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1           (n) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise  
2 dispose of any property, real, personal, or mixed;

3           (o) Establish a budget and make expenditures;

4           (p) Adopt a seal and bylaws governing the management and operation of the  
5 interstate commission;

6           (q) Report annually to the legislatures and governors of the member states  
7 concerning the activities of the interstate commission during the preceding year.  
8 Such reports shall also include reports of financial audits and any recommendations  
9 that may have been adopted by the interstate commission;

10          (r) Coordinate education, training, and public awareness regarding the  
11 compact, its implementation, and its operation;

12          (s) Maintain records in accordance with the bylaws;

13          (t) Seek and obtain trademarks, copyrights, and patents; and

14          (u) Perform such functions as may be necessary or appropriate to achieve the  
15 purposes of the compact.

16          **(13) SECTION 13 — FINANCE POWERS.** (a) The interstate commission may levy on  
17 and collect an annual assessment from each member state to cover the cost of the  
18 operations and activities of the interstate commission and its staff. The total  
19 assessment must be sufficient to cover the annual budget approved each year for  
20 which revenue is not provided by other sources. The aggregate annual assessment  
21 amount shall be allocated upon a formula to be determined by the interstate  
22 commission, which shall promulgate a rule binding upon all member states.

23          (b) The interstate commission shall not incur obligations of any kind prior to  
24 securing the funds adequate to meet the same.

**BILL**

1 (c) The interstate commission shall not pledge the credit of any of the member  
2 states, except by, and with the authority of, the member state.

3 (d) The interstate commission shall be subject to a yearly financial audit  
4 conducted by a certified or licensed public accountant and the report of the audit  
5 shall be included in the annual report of the interstate commission.

6 **(14) SECTION 14 — ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION.**

7 (a) The interstate commission shall, by a majority of commissioners present and  
8 voting, adopt bylaws to govern its conduct as may be necessary or appropriate to  
9 carry out the purposes of the compact within 12 months of the first interstate  
10 commission meeting.

11 (b) The interstate commission shall elect or appoint annually from among its  
12 commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom  
13 shall have such authority and duties as may be specified in the bylaws. The  
14 chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall  
15 preside at all meetings of the interstate commission.

16 (c) Officers selected in par. (b) shall serve without remuneration from the  
17 interstate commission.

18 (d) 1. The officers and employees of the interstate commission shall be immune  
19 from suit and liability, either personally or in their official capacity, for a claim for  
20 damage to or loss of property or personal injury or other civil liability caused or  
21 arising out of, or relating to, an actual or alleged act, error, or omission that occurred,  
22 or that such person had a reasonable basis for believing occurred, within the scope  
23 of interstate commission employment, duties, or responsibilities; provided that such  
24 person shall not be protected from suit or liability for damage, loss, injury, or liability  
25 caused by the intentional or willful and wanton misconduct of such person.

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1           2. The liability of the executive director and employees of the interstate  
2 commission or representatives of the interstate commission, acting within the scope  
3 of such person's employment or duties for acts, errors, or omissions occurring within  
4 such person's state, may not exceed the limits of liability set forth under the  
5 constitution and laws of that state for state officials, employees, and agents. The  
6 interstate commission is considered to be an instrumentality of the states for the  
7 purposes of any such action. Nothing in this paragraph shall be construed to protect  
8 such person from suit or liability for damage, loss, injury, or liability caused by the  
9 intentional or willful and wanton misconduct of such person.

10           3. The interstate commission shall defend the executive director, its employees,  
11 and subject to the approval of the attorney general or other appropriate legal counsel  
12 of the member state represented by an interstate commission representative, shall  
13 defend such interstate commission representative in any civil action seeking to  
14 impose liability arising out of an actual or alleged act, error or omission that occurred  
15 within the scope of interstate commission employment, duties or responsibilities, or  
16 that the defendant had a reasonable basis for believing occurred within the scope of  
17 interstate commission employment, duties, or responsibilities, provided that the  
18 actual or alleged act, error, or omission did not result from intentional or willful and  
19 wanton misconduct on the part of such person.

20           4. To the extent not covered by the state involved, member state, or the  
21 interstate commission, the representatives or employees of the interstate  
22 commission shall be held harmless in the amount of a settlement or judgment,  
23 including attorney fees and costs, obtained against such persons arising out of an  
24 actual or alleged act, error, or omission that occurred within the scope of interstate  
25 commission employment, duties, or responsibilities, or that such persons had a

**BILL**

1 reasonable basis for believing occurred within the scope of interstate commission  
2 employment, duties, or responsibilities, provided that the actual or alleged act, error,  
3 or omission did not result from intentional or willful and wanton misconduct on the  
4 part of such persons.

5 **(15) SECTION 15 – RULE-MAKING FUNCTIONS OF THE INTERSTATE COMMISSION. (a)**

6 The interstate commission shall promulgate reasonable rules in order to effectively  
7 and efficiently achieve the purposes of the compact. Notwithstanding the foregoing,  
8 in the event the interstate commission exercises its rule-making authority in a  
9 manner that is beyond the scope of the purposes of the compact, or the powers  
10 granted hereunder, then such an action by the interstate commission shall be invalid  
11 and have no force or effect.

12 (b) Rules deemed appropriate for the operations of the interstate commission  
13 shall be made pursuant to a rule-making process that substantially conforms to the  
14 “Model State Administrative Procedure Act” of 2010, and subsequent amendments  
15 thereto.

16 (c) Not later than 30 days after a rule is promulgated, any person may file a  
17 petition for judicial review of the rule in the United States District Court for the  
18 District of Columbia or the federal district where the interstate commission has its  
19 principal offices, provided that the filing of such a petition shall not stay or otherwise  
20 prevent the rule from becoming effective unless the court finds that the petitioner  
21 has a substantial likelihood of success. The court shall give deference to the actions  
22 of the interstate commission consistent with applicable law and shall not find the  
23 rule to be unlawful if the rule represents a reasonable exercise of the authority  
24 granted to the interstate commission.

**BILL**

1           **(16) SECTION 16 — OVERSIGHT OF INTERSTATE COMPACT.** (a) The executive,  
2 legislative, and judicial branches of state government in each member state shall  
3 enforce the compact and shall take all actions necessary and appropriate to  
4 effectuate the compact’s purposes and intent. The provisions of the compact and the  
5 rules promulgated hereunder shall have standing as statutory law but shall not  
6 override existing state authority to regulate the practice of medicine.

7           (b) All courts shall take judicial notice of the compact and the rules in any  
8 judicial or administrative proceeding in a member state pertaining to the subject  
9 matter of the compact which may affect the powers, responsibilities or actions of the  
10 interstate commission.

11           (c) The interstate commission shall be entitled to receive all service of process  
12 in any such proceeding, and shall have standing to intervene in the proceeding for  
13 all purposes. Failure to provide service of process to the interstate commission shall  
14 render a judgment or order void as to the interstate commission, the compact, or  
15 promulgated rules.

16           **(17) SECTION 17 — ENFORCEMENT OF INTERSTATE COMPACT.** (a) The interstate  
17 commission, in the reasonable exercise of its discretion, shall enforce the provisions  
18 and rules of the compact.

19           (b) The interstate commission may, by majority vote of the commissioners,  
20 initiate legal action in the United States District Court for the District of Columbia,  
21 or, at the discretion of the interstate commission, in the federal district where the  
22 interstate commission has its principal offices, to enforce compliance with the  
23 provisions of the compact, and its promulgated rules and bylaws, against a member  
24 state in default. The relief sought may include both injunctive relief and damages.

**BILL**

1 In the event judicial enforcement is necessary, the prevailing party shall be awarded  
2 all costs of such litigation including reasonable attorney fees.

3 (c) The remedies herein shall not be the exclusive remedies of the interstate  
4 commission. The interstate commission may avail itself of any other remedies  
5 available under state law or the regulation of a profession.

6 **(18) SECTION 18 — DEFAULT PROCEDURES.** (a) The grounds for default include, but  
7 are not limited to, failure of a member state to perform such obligations or  
8 responsibilities imposed upon it by the compact, or the rules and bylaws of the  
9 interstate commission promulgated under the compact.

10 (b) If the interstate commission determines that a member state has defaulted  
11 in the performance of its obligations or responsibilities under the compact, or the  
12 bylaws or promulgated rules, the interstate commission shall:

13 1. Provide written notice to the defaulting state and other member states, of  
14 the nature of the default, the means of curing the default, and any action taken by  
15 the interstate commission. The interstate commission shall specify the conditions  
16 by which the defaulting state must cure its default; and

17 2. Provide remedial training and specific technical assistance regarding the  
18 default.

19 (c) If the defaulting state fails to cure the default, the defaulting state shall be  
20 terminated from the compact upon an affirmative vote of a majority of the  
21 commissioners and all rights, privileges, and benefits conferred by the compact shall  
22 terminate on the effective date of termination. A cure of the default does not relieve  
23 the offending state of obligations or liabilities incurred during the period of the  
24 default.

**BILL**

1 (d) Termination of membership in the compact shall be imposed only after all  
2 other means of securing compliance have been exhausted. Notice of intent to  
3 terminate shall be given by the interstate commission to the governor, the majority  
4 and minority leaders of the defaulting state's legislature, and each of the member  
5 states.

6 (e) The interstate commission shall establish rules and procedures to address  
7 licenses and physicians that are materially impacted by the termination of a member  
8 state, or the withdrawal of a member state.

9 (f) The member state which has been terminated is responsible for all dues,  
10 obligations, and liabilities incurred through the effective date of termination  
11 including obligations, the performance of which extends beyond the effective date of  
12 termination.

13 (g) The interstate commission shall not bear any costs relating to any state that  
14 has been found to be in default or which has been terminated from the compact,  
15 unless otherwise mutually agreed upon in writing between the interstate  
16 commission and the defaulting state.

17 (h) The defaulting state may appeal the action of the interstate commission by  
18 petitioning the United States District Court for the District of Columbia or the  
19 federal district where the interstate commission has its principal offices. The  
20 prevailing party shall be awarded all costs of such litigation including reasonable  
21 attorney fees.

22 **(19) SECTION 19 — DISPUTE RESOLUTION.** (a) The interstate commission shall  
23 attempt, upon the request of a member state, to resolve disputes which are subject  
24 to the compact and which may arise among member states or member boards.

**BILL**

1 (b) The interstate commission shall promulgate rules providing for both  
2 mediation and binding dispute resolution as appropriate.

3 **(20) SECTION 20 — MEMBER STATES, EFFECTIVE DATE AND AMENDMENT.** (a) Any state  
4 is eligible to become a member state of the compact.

5 (b) The compact shall become effective and binding upon legislative enactment  
6 of the compact into law by no less than 7 states. Thereafter, it shall become effective  
7 and binding on a state upon enactment of the compact into law by that state.

8 (c) The governors of non-member states, or their designees, shall be invited to  
9 participate in the activities of the interstate commission on a non-voting basis prior  
10 to adoption of the compact by all states.

11 (d) The interstate commission may propose amendments to the compact for  
12 enactment by the member states. No amendment shall become effective and binding  
13 upon the interstate commission and the member states unless and until it is enacted  
14 into law by unanimous consent of the member states.

15 **(21) SECTION 21 — WITHDRAWAL.** (a) Once effective, the compact shall continue  
16 in force and remain binding upon each and every member state; provided that a  
17 member state may withdraw from the compact by specifically repealing the statute  
18 which enacted the compact into law.

19 (b) Withdrawal from the compact shall be by the enactment of a statute  
20 repealing the same, but shall not take effect until one year after the effective date  
21 of such statute and until written notice of the withdrawal has been given by the  
22 withdrawing state to the governor of each other member state.

23 (c) The withdrawing state shall immediately notify the chairperson of the  
24 interstate commission in writing upon the introduction of legislation repealing the  
25 compact in the withdrawing state.

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1 (d) The interstate commission shall notify the other member states of the  
2 withdrawing state's intent to withdraw within 60 days of its receipt of notice  
3 provided under par. (c).

4 (e) The withdrawing state is responsible for all dues, obligations and liabilities  
5 incurred through the effective date of withdrawal, including obligations, the  
6 performance of which extend beyond the effective date of withdrawal.

7 (f) Reinstatement following withdrawal of a member state shall occur upon the  
8 withdrawing state reenacting the compact or upon such later date as determined by  
9 the interstate commission.

10 (g) The interstate commission is authorized to develop rules to address the  
11 impact of the withdrawal of a member state on licenses granted in other member  
12 states to physicians who designated the withdrawing member state as the state of  
13 principal license.

14 **(22) SECTION 22 — DISSOLUTION.** (a) The compact shall dissolve effective upon  
15 the date of the withdrawal or default of the member state which reduces the  
16 membership in the compact to one member state.

17 (b) Upon the dissolution of the compact, the compact becomes null and void and  
18 shall be of no further force or effect, and the business and affairs of the interstate  
19 commission shall be concluded and surplus funds shall be distributed in accordance  
20 with the bylaws.

21 **(23) SECTION 23 — SEVERABILITY AND CONSTRUCTION.** (a) The provisions of the  
22 compact shall be severable, and if any phrase, clause, sentence, or provision is  
23 deemed unenforceable, the remaining provisions of the compact shall be enforceable.

24 (b) The provisions of the compact shall be liberally construed to effectuate its  
25 purposes.

**BILL**

1 (c) Nothing in the compact shall be construed to prohibit the applicability of  
2 other interstate compacts to which the states are members.

3 **(24) SECTION 24 — BINDING EFFECT OF COMPACT AND OTHER LAWS.** (a) Nothing  
4 herein prevents the enforcement of any other law of a member state that is not  
5 inconsistent with the compact.

6 (b) All laws in a member state in conflict with the compact are superseded to  
7 the extent of the conflict.

8 (c) All lawful actions of the interstate commission, including all rules and  
9 bylaws promulgated by the commission, are binding upon the member states.

10 (d) All agreements between the interstate commission and the member states  
11 are binding in accordance with their terms.

12 (e) In the event any provision of the compact exceeds the constitutional limits  
13 imposed on the legislature of any member state, such provision shall be ineffective  
14 to the extent of the conflict with the constitutional provision in question in that  
15 member state.

16 **448.981 Implementation of the interstate medical licensure compact.**

17 **(1)** In this section:

18 (a) “Board” means the medical examining board.

19 (b) “Compact” means the interstate medical licensure compact entered into  
20 under s. 448.980.

21 (c) “Expedited license” has the meaning given in s. 448.980 (2) (d).

22 (d) “Interstate commission” has the meaning given in s. 448.980 (2) (e).

23 (e) “Member board” has the meaning given in s. 448.980 (2) (h).

24 (f) “Member state” has the meaning given in s. 448.980 (2) (i).

25 (g) “State of principal license” has the meaning given in s. 448.980 (2) (o).

**BILL**

1           (2) Notwithstanding s. 448.980 and any rules promulgated by the interstate  
2 commission under s. 448.980, the board may only disclose information about an  
3 individual pursuant to the compact if the information meets all of the following  
4 criteria:

5           (a) Any of the following applies:

6           1. The individual has a current expedited license granted by the board  
7 pursuant to the compact.

8           2. The individual has a current expedited license granted by another member  
9 state or is applying to receive an expedited license in another member state, and  
10 Wisconsin is currently designated as his or her state of principal license.

11           3. The individual is requesting to designate Wisconsin as his or her state of  
12 principal license pursuant to the compact.

13           4. The individual is applying to receive an expedited license to practice in  
14 Wisconsin pursuant to the compact.

15           (b) The information is provided only to a member board with responsibility for  
16 authorizing the practice of medicine in the member state or to the interstate  
17 commission.

18           (c) If the information pertains to an investigation or discipline, all identifying  
19 information of individuals or entities other than the individual being investigated  
20 or disciplined is removed.

21           (d) The information is not confidential under the laws of this state.

22           (3) A subpoena issued pursuant to s. 448.980 (9) (c) shall only be enforceable  
23 in this state or against a citizen of this state if all of the following apply:

24           (a) The subpoena is issued by a member board with responsibility for  
25 authorizing the practice of medicine in the member state.

**BILL**

1 (b) The individual being subpoenaed is one of the following:

2 1. A physician with a current expedited license granted by the board pursuant  
3 to the compact.

4 2. A physician with a current expedited license granted by another member  
5 state, and Wisconsin is currently designated as the physician's state of principal  
6 license.

7 (4) In applying s. 448.980 (9) (e), the board may only undertake such  
8 investigation of violations of another state's statute authorizing the practice of  
9 medicine if one of the following applies:

10 1. The physician being investigated has a current expedited license that was  
11 granted by the board and a current expedited license that was granted by the other  
12 state pursuant to the compact.

13 2. The physician being investigated has a current expedited license that was  
14 granted by the board pursuant to the compact and the other state is the physician's  
15 currently designated state of principal license.

16 3. The physician being investigated has a current expedited license that was  
17 granted by the other state pursuant to the compact and Wisconsin is the physician's  
18 currently designated state of principal license.

19 (5) The board shall, by January 1 of each year, report to the members of the joint  
20 committee on finance the number of individuals investigated by the board solely  
21 pursuant to s. 448.980 (9) (e) and the expenses incurred by the board undertaking  
22 investigations pursued solely pursuant to s. 448.980 (9) (e).

23 (6) The payment of assessments for the interstate medical licensure compact  
24 under s. 448.980 (13) (a) shall be made from the appropriation account under s.  
25 20.165 (1) (hg) using the licensure fees paid by physicians licensed under the

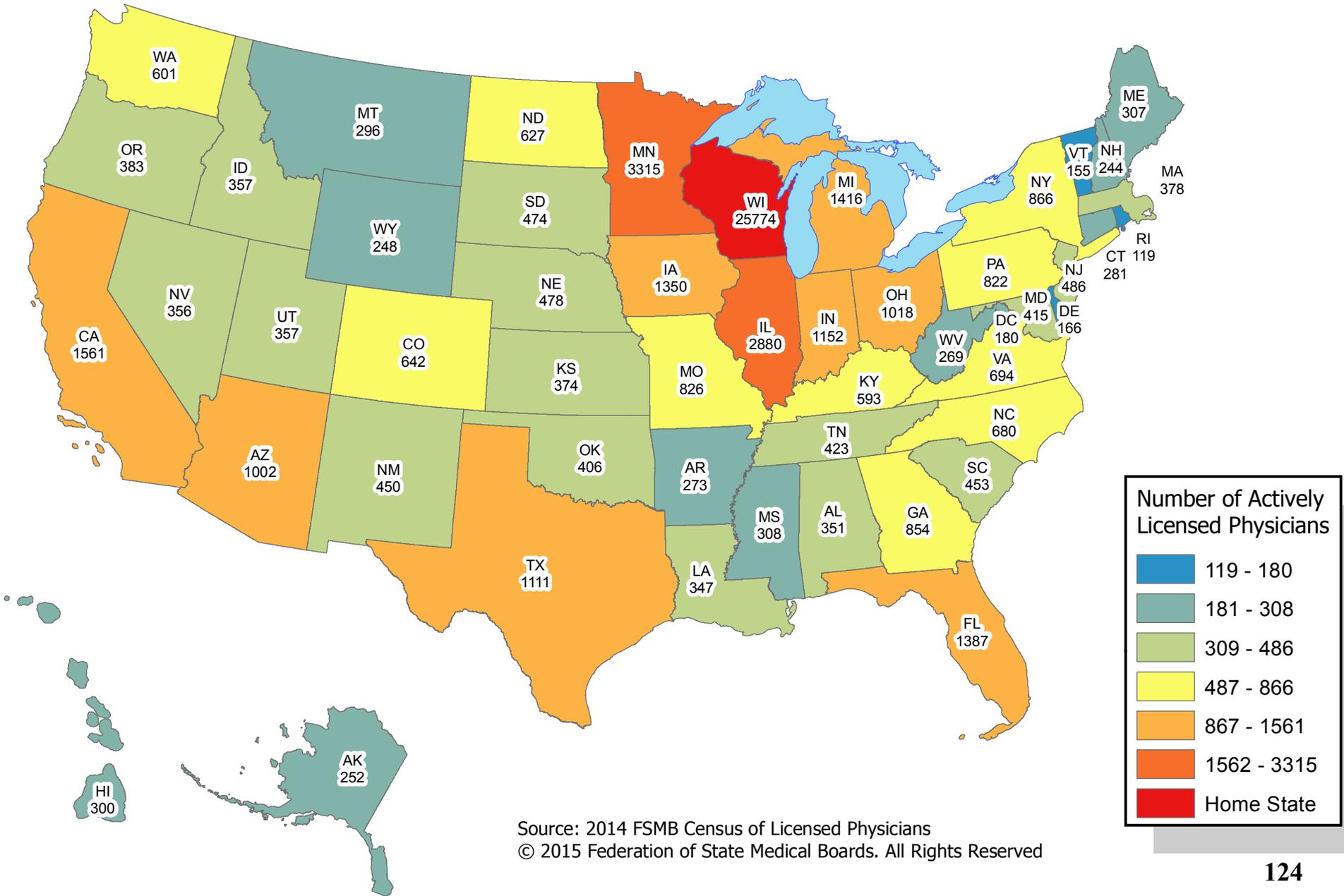
**BILL**

1 compact. No fees from physicians that have not applied for licensure through the  
2 compact shall be used to pay Wisconsin’s annual assessment pursuant to s. 448.980  
3 (13) (a) without the approval of the joint committee on finance.

4 (END)

# Wisconsin Medical Examining Board

## Actively Licensed Physicians with Licenses in Other States



Source: 2014 FSMB Census of Licensed Physicians  
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