

# Wisconsin Department of Safety and Professional Services

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1400 E. Washington Avenue  
Madison, WI 53703

E-Mail: web@dps.wi.gov  
Website: http://dps.wi.gov

## MEDICAL EXAMINING BOARD

### APPLICATION FOR RE-REGISTRATION OF LICENSE TO PRACTICE MEDICINE AND SURGERY

Wisconsin Statutes provide that the board may require an individual who has not registered for five consecutive years to demonstrate his fitness to practice before permitting such person to be re-registered.

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

PLEASE TYPE OR PRINT IN INK  Your name and address are available to the public.  
 Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth ____ month ____ day ____ year	Daytime Telephone Number (____) _____ - _____
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Ethnic/gender status information is optional. Sex:  M  F Ethnic:  White, not of Hispanic origin  Black, not of Hispanic origin  Hispanic  American Indian or Alaskan  Asian or Pacific Islander  Other

Medical School: \_\_\_\_\_  
School Address: \_\_\_\_\_  
(City) (State/Country)  
Date Diploma Granted: \_\_\_\_\_  
month/day/year  
Degree: \_\_\_\_\_

Specialty: \_\_\_\_\_  
Specialty Code: \_\_\_\_\_

<b>BOARD OFFICE USE ONLY</b> School Code: _____ Procedure Code: _____
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**APPLICATION FEES:** Make one check payable to DSPS for the total DSPS fee and attach to this application.

\$141.00 Re-Registration Fee  
\$ 75.00 State Law Exam  
\$ 25.00 Late Renewal Fee  
**\$241.00 \*Total fee attached**

#### \*ORAL EXAMINATION FEE: \$266.00

If you should be selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for the exam.

For Receiving Use Only

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

- |   |   |
|---|---|
| <p>Fee attached to application (Form #1542).</p> <p>Work History (Form 1934).</p> <p>Hospital Verification-Privileges, Employment or Appointment (Form #2167).</p> <p>Physician Profile Data Report from the American Medical Association or American Osteopathic Association.</p> <p>Signed Authorization &amp; Waiver Form (#571).</p> <p>Disciplinary Inquiry Report from the Federation of State Medical Boards (Form #1445).</p> | <p>National Practitioner Data Bank Report (See instructions to obtain).</p> <p>Letters from all State Boards where licensed (includes active and inactive licenses).</p> <p>Wisconsin Statutes and Rules Examination Booklet with answer sheet.</p> <p>Copies of malpractice suit. Court documents with allegations and settlement.</p> <p>Convictions &amp; Pending Charges form (if applicable.)</p> <p>Copies of Continuing Medical Education credits. 30 hours of Category I AMA or AOA. Biennium from 1/1/even – 12/31/odd</p> |
|---|---|

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

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

	SCHOOL	DEGREE	DATES OF GRADUATION (month / day / year)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

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

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

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

SPECIALTY BOARD CERTIFICATIONS	DATE CERTIFIED
_____	_____

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

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

**I AM CURRENTLY OR HAVE BEEN CREDENTIALLED IN THE FOLLOWING U.S. STATES OR TERRITORIES AND CANADIAN PROVINCES OR TERRITORIES UNLIMITED (INCLUDE ACTIVE AND INACTIVE CREDENTIALS):**

By Written Exam: \_\_\_\_\_

By Endorsement/Reciprocity: \_\_\_\_\_

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

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

	<u>YES</u>	<u>NO</u>
1. Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever failed to pass any state board examination, national board examination, or USMLE, or FLEX examination? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/>	<input type="checkbox"/>
5. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have any felony or misdemeanor charges pending against you? If yes, submit Convictions and Pending Charges (Form #2252). Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been convicted of a misdemeanor or a felony? If yes, submit Convictions and Pending Charges (Form #2252). Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.	<input type="checkbox"/>	<input type="checkbox"/>

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- |   | <u>YES</u>               | <u>NO</u>                |
|---|--------------------------|--------------------------|
| 8. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.  | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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

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

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

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

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

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 14. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.           | <input type="checkbox"/> | <input type="checkbox"/> |

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- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 18. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Are you currently engaged in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

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## CERTIFICATION OF LEGAL STATUS.

I declare under penalty of law that I am (check one):

\_\_\_\_\_ a citizen or national of the United States, or

\_\_\_\_\_ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at <http://www.uscis.gov>.

## ALL APPLICANTS MUST COMPLETE THIS SECTION

### AFFIDAVIT OF APPLICANT

(Sign and date in the presence of a notary)

**I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

State of \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and sworn to before this \_\_\_\_\_ day of

\_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_

(Applicant name)

\_\_\_\_\_  
Signature of Notary Public

**S E A L**

\_\_\_\_\_  
Date Commission Expires

