

Wisconsin Department of Safety and Professional Services

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

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

1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@dsps.wi.gov
Website: <http://dsps.wi.gov>

PODIATRY AFFILIATED CREDENTIALING BOARD

APPLICATION FOR A TEMPORARY EDUCATIONAL LICENSE TO PRACTICE PODIATRIC MEDICINE AND SURGERY

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

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)

PLEASE TYPE OR PRINT IN INK

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

Have you ever held a license/credential in the state of Wisconsin? ____ Yes ____ No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

School Name: _____ Date of Graduation: _____ month/day/year

Degree: _____ Specialty: _____

ACCOUNT FOR ALL ACTIVITIES FROM THE DATE OF GRADUATION FROM A PODIATRIC SCHOOL TO THE PRESENT TIME. MUST INCLUDE PROFESSIONAL AND NONPROFESSIONAL ACTIVITIES.

INTERNSHIPS:

<u>HOSPITAL</u>	<u>LOCATION</u>	<u>BEGINNING DATE</u> mo/yr	<u>ENDING DATE</u> mo/yr
1. _____	_____	_____	_____
2. _____	_____	_____	_____

RESIDENCIES OR FELLOWSHIPS:

<u>NAME OF HOSPITAL OR CLINIC</u>	<u>LOCATION</u>	<u>DATES (from - to)</u> mo/yr
1. _____	_____	_____
2. _____	_____	_____

<u>PRACTICE</u>	<u>LOCATION</u>	<u>DATES (from - to)</u> mo/yr
1. _____	_____	_____
2. _____	_____	_____

APPLICATION MUST BE ACCOMPANIED BY: Make one check payable to DSPS for the total DSPS fee and attach to this application.

\$ 10.00 Initial Credential Fee
\$ 75.00 Wisconsin Statutes and Rules Examination
\$ 85.00 Total DSPS Fee

For Receiving Use Only

Wisconsin Department of Safety and Professional Services

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

- | | |
|---|---|
| Application (Form #2153) | Wisconsin Statutes and Rules Examination |
| Copy of Professional Diploma and translation if necessary | Convictions & Pending Charges Form (Form #2252), if applicable |
| Fee attached to application (Form #2153) | |

- | | <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 podiatric board examination, national board examination, NBPME, or PMLEXIS 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, attach a sheet providing details about the pending charge, including status of the charge and the location of court. (Please do not give details on minor traffic charges, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction court, and penalty. (Please do not give details on minor traffic convictions, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 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, if applicable, list name, address and phone number of 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"/> |

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

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

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

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

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

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

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

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 14. Do you have a medical condition which in any way impairs or limits your ability to practice podiatric medicine and surgery with reasonable skill and safety? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does your use of chemical substance(s) in any way impair or limit your ability to practice podiatric medicine and surgery with reasonable skill and safety? If yes, please explain. | <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"/> |
| 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>.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

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

AFFIDAVIT OF APPLICANT

I 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 of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Applicant Signature: _____ Date: _____

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AFFIDAVIT OF HOSPITAL AUTHORITY

To be completed by a licensed Wisconsin Podiatrist of the hospital who will be directing the applicants training program.

_____, _____,
(Name of Applicant) (Address)
a graduate of the _____ Podiatric Medicine and Surgery School,
(Name of School)
_____, has made application for post-graduate training in this
(Address of School)
hospital, the _____
(Name of Hospital)

_____ under the provision of a Temporary Educational License,
(Address of Hospital)
which will entitle him/her to receive training under the direction of a licensed Wisconsin podiatrist for a period not to exceed one year.

We have examined the credentials of Doctor _____ and find that they meet the requirements of the Podiatrist Affiliated Credentialing Boards regulations governing these permits, and are satisfactory to this Hospital. I hereby recommend that the board consider the application of Doctor _____
_____ for a Temporary Educational License, with his/her post-graduate training to begin in this hospital on _____, 20____.

Signature of Licensed Wisconsin Podiatrist

Name of Hospital

Print Name

Address of Hospital

Wisconsin Podiatric and Surgery License #

Date

HOSPITAL SEAL