Licensing Session

Before the Session:

- **Use photocopier to make copies**
  - Diploma 2 copies
  - Name change documents 3 copies
- **Cut photo from sheets provided if you didn’t bring a 2 x 2 photo.**
- **Print your name on back of the photo**
- **Envelopes: put your initials on the back corner – just in case.**
- **Pick up supplies: post-it notes, clips, & pens**
Introductions

- **GME Staff:** Debra Coe-Bradish, Jeanne Sarbacker, Cindy Feuling, Randa Wilberg, Lisa Brewer

- **Program Coordinators:** Rebecca Forbes
You will be given time to complete the forms as we proceed. Please try to keep up.

This session is geared toward individuals who graduated from Medical School in the spring of 2009.

We will collect the forms that need to be notarized and return them to you, if necessary.
Fees: What does the hospital pay for?

- **Licensure:** The hospital will reimburse PGY-2 residents the initial license application fee ($147 or $132) upon receipt of full licensure. You are required to pay the initial license fee up front.

- **TEP:** The hospital will pay the $10 fee directly to the Medical Examining Board when we submit your application this spring.

- All other licensure fees are your responsibility.
DEA fees

- DEA: The hospital will pay initial and renewal fees ($551) to cover your training period at UWHC.

- The GME office will apply for your DEA automatically when you are fully licensed.

- During the last year of training the DEA fee will be a pro-rated portion of the renewal fee.
When should everything be submitted?

March 1, 2010

This should ensure

- you don’t miss any USMLE deadlines
- ability to sit for Step 3 as soon as possible
Taking Step 3 out of State

Pros:
- Can schedule/take Step 3 earlier than May 2010.
- Medical School knowledge is still with you.

Cons:
- You will only get licensed 1-2 months earlier than those taking Step 3 in Wisconsin.
- Cost for travel out of state
- AMA profile needs to be filled out ~ Additional $31
- Disciplinary form needs to be filled out
- EBHAR form needs to be sent AFTER passing Step 3 to report all three scores.
Merck Loan

- $1000 loan at 2% interest
- Automatic payroll deductions
- Applications available in the GME Office H4/833
Envelopes

- Envelopes will be collected when indicated. Seal the envelope before handing in if all items are completed.

- Place your **initials** on the back of each envelope, in case you need to find it again.
Other Envelopes

- **For DO's Only:** AOA Request for Physician Profile Form ~ Use AOA envelope.

- Blank Envelopes: use for
  - Medical Education Verification Form
  - Non-UWHC GME training programs if applicable
  - Hospital, Facility, & Employment Verification for moonlighting or other employment in the past 5 years if applicable
FSMB Envelopes

Three Separate Envelopes:

- Request for Exam and Board History Report Form: use envelope with BLUE dot (EBAHR form)
- USMLE Step 3 Exam Fee Form: use envelope with RED dot (Form S3-08-WI).

If you have already passed Step 3, this envelope will be needed for the Board Action Databank Inquiry Form: use envelope with GREEN dot (Form 1445).
Name Changes

- Is the name on all your credentials (diploma, USMLE scores) the same?
- If not, submit legal documentation (marriage certificate, divorce decree, etc.) of the change with your:
  - USMLE Step 3 Application (Form 13)
  - Application for Licensure (Form 570)
  - Application for TEP (Form 564)
Address Changes

Be sure to keep both the DRL and the USMLE informed about any address changes. If you don’t, it may lead to missing deadlines and extra fees.
### Wisconsin Department of Regulation & Licensing

**CODES FOR SPECIALTIES:**

Enter only one specialty code on the "APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY" (FORM #570)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Medicine</td>
<td>37</td>
</tr>
<tr>
<td>Administrative Medicine</td>
<td>71</td>
</tr>
<tr>
<td>Aerospace Medicine</td>
<td>33</td>
</tr>
<tr>
<td>Alcoholism - Chemical Dependency</td>
<td>49</td>
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<tr>
<td>Allergy - Immunology</td>
<td>01</td>
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<tr>
<td>Anesthesiology</td>
<td>02</td>
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<tr>
<td>Aviation Medicine</td>
<td>32</td>
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<tr>
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<td>03</td>
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<tr>
<td>Emergency Medicine</td>
<td>31</td>
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<tr>
<td>Endocrinology</td>
<td>.56</td>
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<tr>
<td>Family Practice</td>
<td>41</td>
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<tr>
<td>Gastroenterology</td>
<td>06</td>
</tr>
<tr>
<td>General Practice</td>
<td>08</td>
</tr>
<tr>
<td>Genetics</td>
<td>61</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>29</td>
</tr>
<tr>
<td>Hand Surgery</td>
<td>64</td>
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<tr>
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<td>07</td>
</tr>
<tr>
<td>Hyperbaric Medicine</td>
<td>65</td>
</tr>
<tr>
<td>Immunology - Infectious Diseases</td>
<td>47</td>
</tr>
<tr>
<td>Institutional Medicine</td>
<td>39</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>04</td>
</tr>
<tr>
<td>Internal Medicine - Cardiology</td>
<td>05</td>
</tr>
<tr>
<td>Internal Medicine - Pulmonary Medicine</td>
<td>45</td>
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<tr>
<td>Neorontology</td>
<td>63</td>
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<tr>
<td>Nephrology</td>
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<tr>
<td>Neurology</td>
<td>10</td>
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<tr>
<td>Neuropsychology</td>
<td>51</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>23</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>12</td>
</tr>
<tr>
<td>Occupational Medicine</td>
<td>30</td>
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<tr>
<td>Oncology</td>
<td>38</td>
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<tr>
<td>Ophthalmology</td>
<td>13</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>14</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>67</td>
</tr>
<tr>
<td>Otorhinolaryngology - Ent</td>
<td>15</td>
</tr>
<tr>
<td>Pain</td>
<td>66</td>
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<tr>
<td>Pathology</td>
<td>16</td>
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<tr>
<td>Pathology - Clinical</td>
<td>17</td>
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<tr>
<td>Pathology - Surgical Anatomic</td>
<td>72</td>
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<tr>
<td>Pediatrics</td>
<td>18</td>
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<tr>
<td>Pediatrics - Other</td>
<td>60</td>
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<tr>
<td>Perinatology</td>
<td>62</td>
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<tr>
<td>Pharmacology - Clinical</td>
<td>48</td>
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<tr>
<td>Physical Medicine and Rehabilitation</td>
<td>19</td>
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<tr>
<td>Preventive Medicine</td>
<td>09</td>
</tr>
<tr>
<td>Proctology</td>
<td>36</td>
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<tr>
<td>Psychiatry</td>
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<tr>
<td>Psychiatry - Child</td>
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<td>Public Health</td>
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<tr>
<td>Radiation - Oncology</td>
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<td>Radiology</td>
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<td>Radiology - Diagnostic</td>
<td>43</td>
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<td>Radiology - Nuclear Medicine</td>
<td>68</td>
</tr>
<tr>
<td>Radiology - Ultrasound</td>
<td>69</td>
</tr>
<tr>
<td>Research</td>
<td>34</td>
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<tr>
<td>Retired</td>
<td>24</td>
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<tr>
<td>Rheumatology</td>
<td>57</td>
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<tr>
<td>School Physician</td>
<td>52</td>
</tr>
<tr>
<td>Surgery - Cardiovascular</td>
<td>44</td>
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<tr>
<td>Surgery - Colon and Rectal</td>
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<tr>
<td>Surgery - General</td>
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<tr>
<td>Surgery - Maxillofacial</td>
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<tr>
<td>Surgery - Neurological</td>
<td>11</td>
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<tr>
<td>Surgery - Peripheral Vascular</td>
<td>59</td>
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<tr>
<td>Surgery - Plastic</td>
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<tr>
<td>Surgery - Thoracic</td>
<td>27</td>
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<tr>
<td>Urology</td>
<td>28</td>
</tr>
</tbody>
</table>

Find your specialty code and enter code on Form 570 shown on the next page.
Wisconsin Department of Regulation & Licensing

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

FAX #: (608) 261-2083
Phone #: (608) 266-3112

MEDICAL EXAMINING BOARD

APPLICATION FOR LICENSE TO PRACTICE 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.).

Please type or print in ink Your name and address are available to the public. Check box if you wish your name and address withheld from list of 10 or more credential holders (sec. 440.16, Stats.).

Last Name  First Name  MI  Middle Name(s)

Street Address, City, State Zip

Mail To Address (if different)

Date of Birth

Month  Day  Year

Daytime Telephone Number

Telephone

Sex: M  F  E  Unknown

Ethnicity: White, not of Hispanic origin
Black, not of Hispanic origin
American Indian or Alaskan
Asian or Pacific Islander
Hispanic
Other

Medical School
City, State

Degree
Degree Granted:

Medical School Address:

Medical School:

Specialty:

Specialty Code:

Residency Specialty Code from Previous page

APPLICANT FEES

For Receipt Only Use Only

Included in fee:

Endorsement of LMCC (Taken after 1/1/78) $75.00 Initial Credential Fee $75.00 State Law Exam $132.00 Total Fee Attached

Endorsement of National Boards (MD or DO) $75.00 Initial Credential Fee $57.00 State Law Exam $132.00 Total Fee Attached

Endorsement of FLEX $75.00 Initial Credential Fee $57.00 State Law Exam $132.00 Total Fee Attached

Endorsement of State Boards Exam (Taken Prior to 1/1/78) $141.00 Initial Credential Fee $57.00 State Law Exam $198.00 Total Fee Attached

Endorsement of State Boards Exam (Taken after 1/1/78) $141.00 Initial Credential Fee $75.00 State Law Exam $198.00 Total Fee Attached

Additional fee required for oral examination:

$266.00

If you are applying for USMLE Step 3 and plan to take the exam in Wisconsin, check the box indicated in green on slide.

.include a check for $147

If you plan to take USMLE Step 3 out of state or will be taking COMLEX 3 check the box indicated in blue on slide.

.include a check for $132

Form 570
Page 1 of 6

If you are applying for USMLE Step 3 and plan to take the exam in Wisconsin, check the box indicated in green on slide.

.include a check for $147

If you plan to take USMLE Step 3 out of state or will be taking COMLEX 3 check the box indicated in blue on slide.

.include a check for $132

#570 (Rev. 7/09)
Ch. 448, Stats.

Committee to Equal Opportunity in Employment and Licensing

Page 1 of 6
Wisconsin Department of Regulation & Licensing

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

Applications (Form #570)

Signed Authorization and Waiver Form (Form #571)

Copy of LFPMO certificate if a Foreign Graduate (PCVS)

Physician Profile Data Report from the American Medical Association or American Osteopathic Association

Copy of Professional Diploma and translations if necessary (PCVS)

Disciplinary Inquiry Report from the Federation of State Medical Boards (Form #1445/PCVS)

Medical Education Verification Form (Form #2144/PCVS)

For attachment to application (Form #376)

Certificate of Post-graduate Training (Form #2146/PCVS)

Wisconsin Statutes and Rules Examination

National Board, FLEX, State Board, USMLE or LMAC score (PCVS)

Convictions & Pending Charges Form (Form #2250), if applicable

Week History (Form #1934)

Letter from the employing authority of a medical school in Wisconsin indicating that
the applicant has been invited to serve on the academic staff of such medical school as
a visiting professor. (Only required for visiting professors)

National Practitioner Data Bank Report (not applicable for visiting professors)

Letter from a physician licensed to practice medicine and surgery requesting the
applicant’s services (only required for locum tenens or visiting professor)

Hospital, Facility and Employer Verification Form (Form #2167) (not applicable
for visiting professors)

Copy of a license to practice medicine and surgery in another state or Canada

Do not leave any gaps

COPYRIGHT. DO NOT LEAVE GAPS OF MORE THAN 30 DAYS.

Enter Undergraduate Information

Your Medical School Address Grad Date

Do not leave any gaps

Post-Graduate Training and Fellowship

NAME OF HOSPITAL OR CLINIC

LOCATION

DATES (from - to)

 Nay

Practic means and other activities: Outline in chronological order from the date of completion of your training/fellowship to the present time.

Must include professional and nonprofessional activities. All activities must be authenticated for (Attach additional sheets if necessary)

NAME OF HOSPITAL OR CLINIC

LOCATION

DATES (from - to)

 Nay

BCFMG Exam Taken

Certificate Issued

Certificate No.

Date Issued

Specialty Board Certifications

Attention IMG’s

Page 2 of 6
Form 570
Page 3 of 6

If you have ever been licensed before you must fill out the middle section AND send letters to each past licensing board requesting verification be sent to the WI DRL.

Read the questions at the bottom carefully, the most common answers are checked.

If you have failed a board exam, USMLE, or Comlex you will need to provide an explanation on a separate piece of paper.

Enter any hospitals where you have moonlighted or had staff privileges —most likely none

Failed Exam?

Conviction?

DUI or Underage Drinking ticket?
Form 570
Page 4 of 6

Read the questions carefully.

Wisconsin Department of Regulation & Licensing

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. (If yes, complete Form 2829.)

10. Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet. (If yes, complete Form 2829.)

11. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).

12. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.

13. Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.

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.

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.

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.

16. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.

17. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.

18. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.

19. Are you currently engaged in the illegal use of controlled dangerous substances?

20. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.
Wisconsin Department of Regulation & Licensing

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          Today's Date

State of WI    County of Dane

Subscribed and sworn to before this ______________ day of ____________________, 20__

________________________
Signature of Notary Public

Date Commission Expires

Page 5 of 6
Everyone must include:

- Copy of Diploma
- Check
- Copy of Name change documentation if applicable
- Form must be notarized

Include in ☑️DRL envelope

The DRL will contact you by email regarding any pending items.

---

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied. A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

Print First Name    Middle Initial    Last Name

Medical Resident

Date of Birth (MM/DD/YYYY)

Social Security Number

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program, to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes, and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.

EMAIL ADDRESS:
Do you have an email address? ☑️Yes    ☐No

If yes, this field is required to receive your application status electronically. Your email address must be clearly legible with the correct case sensitive information.

EMAIL ADDRESS: Submit your email address in the spaces provided below or attach a printer copy.

If no, your checklist will be sent by first class mail.

Your UWHC email

---

1 Section 440.03 (11m), Wis. Stats.
2 Sections 49.22, and 440.13, Wis. Stats.
4 Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

Page 6 of 6
Disregard unless you have convictions and Pending Charges to report.

If you have convictions or pending charges such as alcohol violations, including underage drinking, or drug violations you must fill out this form and attach the required documentation.

This form must be notarized and then include in the DRL envelope with a $6 check.

$8 Notary
DRL
Wisconsin Department of Regulation & Licensing

3. Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program? YES NO MO/YR COMPLETED
   Did you successfully complete the program? YES NO
   Please attach the certificate of completion/discharge summary.

(Check all that apply) YES NO MO/YR COMPLETED
4. Have you ever been sentenced to:
   ☐ Probation
   ☐ Parole
   ☐ Ordered to pay restitution
   Did you successfully complete one of the above as ordered by the court?

If you are currently on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are pending. Submit a copy of the police report/criminal complaint for each of the following pending charges.

<table>
<thead>
<tr>
<th>PENDING CHARGE</th>
<th>DATE OF ARREST</th>
<th>LOCATION OF ARREST (city/state)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before notarizing public.

Signature Date
Signed and sworn before me this ________ day of ________, 20____

Signature of Notary Public Date
My commission (is permanent) expires ____________________________ SEALS

Page 2 of 2
## MEDICAL EDUCATION VERIFICATION FORM

**MEDICAL EXAMINING BOARD**

*Not necessary if utilizing FCVS*

**IMPORTANT:** PLEASE FORWARD THIS FORM TO YOUR MEDICAL SCHOOL

The State of Wisconsin requires the following information pertaining to the individual:

<table>
<thead>
<tr>
<th>Applicant's Name:</th>
<th>Medical School:</th>
<th>Soc. Sec. #:</th>
</tr>
</thead>
</table>

**MEDICAL SCHOOL ADDRESS:**

1. Did this physician attend the medical school noted above? **[ ] YES [ ] NO**

2. What were the applicant's dates of enrollment in this medical school? __________________________________________________________

3. Did this physician graduate from this medical school? If no, please attach explanation on a separate sheet.
   - Degree Granted ____________________________
   - Date Degree Granted __________________________

4. Did this individual take a leave of absence during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet. **[ ] YES [ ] NO**

5. Did this individual have a record of unexcused absences during his/her attendance at this medical school? **[ ] YES [ ] NO**

6. Was this individual ever disciplined or under investigation during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet. **[ ] YES [ ] NO**

7. Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? If yes, please attach explanation on a separate sheet. **[ ] YES [ ] NO**

8. Was this individual recommended for post-graduate training? **[ ] YES [ ] NO**

**Print name of Dean** ____________________________

**Signature of Dean** ____________________________

**Date form was completed** ____________________________

*For use in school locating your records

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

#2164 (Rev. 12/27/02) Ch. 448, Stats.

Committed to Equal Opportunity in Employment and Licensing
Form 2165

Complete if you had GME training prior to UWHC.

Send to your previous program(s) for verification.
# Form 1934

Graduates of Spring 2009 complete the top section as indicated. PG-2’s and up must complete in chronological order beginning with your current residency working backwards to medical school. Do not leave any gaps of more than 30 days. If you were traveling, relocating or on medical leave, these must be included.

Include this form in the small manila envelope to the DRL

---

**SECTION A:**

<table>
<thead>
<tr>
<th>Name/Last</th>
<th>First</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you’ve used another name

**SECTION B:**

**NAME/Last**

**First**  
**MI**

**DATE OF BIRTH**

**MM / DD / YY**

**DATE THIS FORM IS COMPLETED**

**Not Applicable**

**Today’s Date**

---

#1934 (Rev. 9/08)
Ch. 448 Stats.

Committed to Equal Opportunity in Employment and Licensing

---
Form 2167
Complete this form if you have had staff privileges or did moonlighting in the past 5 years.

- Research, if paid
- Clinical Instructor
- Worked in a medical clinic

Fill in the top portion and address a blank envelope to the Hospital Medical Staff Office.

Blank

If it does not pertain to you put your name and Not Applicable at the top and include in the small manila envelope to the DRL

DRL
Form 571

This form must be notarized.

After it is notarized include in the small manila envelope to the DRL.

DRL

Wisconsin Department of Regulation & Licensing
Mail To: P.O. Box 8935
Madison, WI 53708-8935

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

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

MEDICAL EXAMINING BOARD

AUTHORIZATION AND WAIVER
(This form may be copied.)

Forward this form to all sources that verify information directly to the Wisconsin Medical Examining Board (example: verification of hospital privileges).

Name

Place of Birth

Date of Birth

Applicant’s Name

City/State/Country of birth

Date of birth

having filed an application for a license to practice medicine and surgery in the State of Wisconsin, hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

I also authorize and request every person, hospital, clinic, community, governmental agency, court, association or institution having control of any documents, records and other information pertaining to me, to furnish to the Wisconsin Medical Examining Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any of its pertinent data and to permit the Wisconsin Medical Examining Board or any of its agents or representatives to inspect and make copies of such documents, records and other information.

I hereby release, discharge, exonerate the Wisconsin Medical Examining Board, its agents and representatives, and any person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information or the investigation made by the Wisconsin Medical Examining Board.

Signature

State of WI County of Dane

Subscribed and sworn to before me this ______ day of _________________________, 20____, by

Print Name

(Applicant name)

Signature of Notary Public

Date Commission Expires

#571 (Rev. 9/08)
Ch. 448, Stats.

Committed to Equal Opportunity in Employment and Licensing
Wisconsin Department of Regulation & Licensing

MEDICAL EXAMINING BOARD
MALPRACTICE SUITS OR CLAIMS FORM

Please Print:
Section A: This form must be completed by the physician listed on the Application Forms (#570, #542).

Name
Printed Name of Physician
Your Address
Address of Physician
City State Zip

Section B: List below all malpractice suits, claims or settlements in which you were involved since the date of your initial licensure as a medical doctor (including post-graduate residency). Provide a brief description of the allegations and final disposition. For any malpractice suits resolved within the past 10 years with a finding of malpractice or negligence provide copies of any pleadings or judgments. (Attach additional sheets if necessary.)

Parties
Date filed Date resolved
Court and Case No Disposition
Description of legal action or claim

#2829 (10/08)
Ch. 448, Stats.

- OVER -

Committed to Equal Opportunity in Employment and Licensing
Wisconsin Department of Regulation & Licensing

<table>
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<tr>
<th>Parties</th>
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<td>Date resolved</td>
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<tr>
<td>Court and Case No.</td>
<td>Disposition</td>
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<tr>
<td>Description of legal action or claim</td>
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</table>

**AFFIDAVIT OF APPLICANT**
The undersigned, having been duly sworn on oath, states that the information and statements herein contained are true and correct based upon personal knowledge of the undersigned.

**Signature**
Signature of Applicant

**Date**
Date

Printed Name of Applicant

State of **WI**
County of **Dane**

Subscribed and sworn before me this _____ day of __________________, 20 __________
by ________________________________
(applicant)

Notary Public, State of ___________________________
My Commission Expires: _______________________

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

Form 2829

This form needs to be notarized if you have a claim against you.

After it is notarized it goes into the small manila envelope to the MEB.

MEB
Form 1935
For Osteopaths only
Complete this form and include in the American Osteopathic Association envelope.

Fees:
AOA Members – No Charge
Non-Member - $20.00

Attn: IMG’s

Your Name: [Surname] [Given Name] [Middle Name]
Your Home Address: [Street Address]
City, State and Zip Code: [City] [State] [Zip Code]
Phone Number: [Phone Number]
Year of Grad for Med School: [Year]
Year of Graduation (from Med School): [Year]
Degree: [Degree]
E.C.F.M.G. Number: [Number]
AOA Number: [Number]
Signature:
Today’s Date: [Date]

ATTENTION: AMERICAN OSTEOPATHIC ASSOCIATION

Please mail the response directly to the Wisconsin Medical Examining Board at the following address:
Department of Regulation & Licensing
Medical Examining Board
PO Box 8935
Madison WI 53708

#1935 (Rev. 9/08)
Ch. 448, Stats.

Committed to Equal Opportunity in Employment and Licensing
Wisconsin Department of Regulation & Licensing
Mail To: P.O. Box 8935
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

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

MEDICAL EXAMINING BOARD
DISCIPLINARY INQUIRIES REPORT
(Not necessary if utilizing FCVS)

APPLICANT: PLEASE COMPLETE THIS FORM AND FORWARD DIRECTLY TO THE FEDERATION OF STATE MEDICAL BOARDS AT THE ADDRESS BELOW:

Federation of State Medical Board, Inc.
Federation Place
P.O. Box 619850
Dallas, TX 75261-9850

The State of Wisconsin requests a Board Action/Disciplinary Search concerning the following individual:

Last, First, Middle Name
Date of Birth (MM/DD/YYYY)
Degree
Medical School
Year of Graduation
SSN
Date of Birth (month/day/year)
Degree
Medical School
Year of Graduation

ATTENTION: FEDERATION OF STATE MEDICAL BOARDS
Please mail the response directly to the Medical Examining Board at the following address:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

#1445 (Rev. 9/08)
Ch. 448, Stats.
Committed to Equal Opportunity in Employment and Licensing

Form 1445
ONLY fill out if you have passed Step 3 or are planning to take it outside of Wisconsin.

FSMB
Wisconsin Department of Regulation & Licensing

Mailing Address:
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@drf.state.wi.us
Website: http://drl.wi.gov

MEDICAL EXAMINING BOARD
APPLICATION FOR TEMPORARY EDUCATIONAL PERMIT

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.

Fields with an asterisk (*) are required.

Print Last Name
First Name
MI

Home Address
City, State, Zip

Date of Birth: MM DD YYYY

Sex: M F
Ethnicity:
White, not of Hispanic origin
American Indian or Alaskan
Black, not of Hispanic origin
Asian or Pacific Islander
Hispanic
Other

Phone Number

Have you ever held a license/credential in the state of Wisconsin? Yes X No (please indicate)

School Name: Your Medical School
Location: City, State, Country

Date Diploma: MM/DD/YYYY
Degree: MD or DO
Specialty:
Program

ACCOUNT FOR ALL ACTIVITIES FROM THE DATE OF GRADUATION FROM MEDICAL SCHOOL TO THE PRESENT TIME. MUST INCLUDE PROFESSIONAL AND NONPROFESSIONAL (PERSONAL) ACTIVITIES. ALL TIME MUST BE ACCOUNTED FOR. (Attach additional sheets if necessary)

INTERNSHIPS:
1. Location: University of Wisconsin Hospital

RESIDENCIES OR FELLOWSHIPS: (Attach additional sheets if necessary)
1. Name of Hospital or Clinic
Location: City, State, Country
Dates: (from - to) mo - yr
2. Practice

APPLICATION MUST BE ACCOMPANIED BY:
1. Fee - $10.00
2. Copy of professional diploma & official translation if necessary.

For Receipt Use Only

Committed to Equal Opportunity in Employment and Licensing

Do not leave any gaps in time.

No check necessary. Hospital will pay this for you.
Same questions as on the full licensure paperwork.

**Conviction?**
- No

**Failed Exam?**
- Yes

**Conviction?**
- No

**DUI or Underage Drinking ticket?**
- No
Wisconsin Department of Regulation & Licensing

For the purposes of questions 12-18, 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.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>13.</td>
<td>Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?</td>
<td>☒</td>
</tr>
<tr>
<td>14.</td>
<td>Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety?</td>
<td>☐</td>
</tr>
<tr>
<td>15.</td>
<td>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?</td>
<td>☐</td>
</tr>
<tr>
<td>16.</td>
<td>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?</td>
<td>☐</td>
</tr>
<tr>
<td>17.</td>
<td>Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?</td>
<td>☒</td>
</tr>
<tr>
<td>18.</td>
<td>Are you currently engaged in the illegal use of controlled dangerous substances?</td>
<td>☒</td>
</tr>
<tr>
<td>19.</td>
<td>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?</td>
<td>☐</td>
</tr>
</tbody>
</table>
Wisconsin Department of Regulation & Licensing

CERTIFICATION OF LEGAL STATUS.
I declare under penalty of law that I am (check one):

☐ 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 WI County of Dane
Subscribed and sworn to before this ______ day of 20__

Signature of Notary Public ___________________________
Date Commission Expires ___________________________

Print Name Here (Applicant name) ___________________________

SEAL

This page must be notarized.
Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied. A form for submitting a statement that you do not have a social security number is available from the department.

(Print First Name) (Middle Initial) (Last Name)

First Name

Middle Initial

Last Name

Medical Resident

Date of Birth (MM/DD/YYYY)

Social Security Number

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and adult support programs, to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes, and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.

EMAIL ADDRESS: Do you have an email address? ☑ Yes ☐ No

If yes, this field is required to receive your application status electronically. Your email address must be clearly legible with the correct case sensitive information.

EMAIL ADDRESS: Submit your email address in the spaces provided below or attach a printer copy.

If no, your checklist will be sent by first class mail.

Your UWHC email

Items to Include

➢ Diploma

If Applicable:

➢ Convictions & Pending charges form

➢ $8 check

➢ Marriage Cert

---

1 Section 440.03 (11m), Wis. Stats.

2 Section 440.12, Wis. Stats.

3 Sections 49.22, and 440.13, Wis. Stats.

4 Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stat. Making a false statement in connection with this application may result in revocation or denial.
If you have convictions or pending charges such as alcohol violations, including underage drinking, or drug violations, you must fill out this form and attach the required documentation.

This form must be notarized and then include in the DRL envelope with a $6 check.

Form 2252

<table>
<thead>
<tr>
<th>Offense</th>
<th>Date</th>
<th>City and State</th>
</tr>
</thead>
</table>

**Notary**

DRL
Wisconsin Department of Regulation & Licensing

3. Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program? YES □ NO □ MO/YR COMPLETED □
   Did you successfully complete the program? YES □ NO □ MO/YR COMPLETED □
   Please attach the certificate of completion/discharge summary.

4. Have you ever been sentenced to: □ Probation □ Parole □ Ordered to pay restitution
   Did you successfully complete one of the above as ordered by the court? YES □ NO □ MO/YR COMPLETED □
   (Check all that apply)

If you are currently on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are pending. Submit a copy of the police report/criminal complaint for each of the following pending charges.

<table>
<thead>
<tr>
<th>PENDING CHARGE</th>
<th>DATE OF ARREST</th>
<th>LOCATION OF ARREST (city/state)</th>
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</thead>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted or to a criminal prosecution. This document must be signed before notarizing.

Signature ____________________________
Today's Date ____________________________

Signed and sworn before me this ___________ day of ____________, 20 ________

Signature of Notary Public ____________________________ Date ____________

My commission (is permanent) _______ expires ____________________________

Page 2 of 2
For USMLE Step 3
Application
Country codes for questions 7 & 8 on the next page

#7- Country of citizenship
#8-Country of Med School

USA code is 099
Do not Fill in # 1 or 2. DRL completes this portion.

Use UPPERCASE Block Letters

Last Name
First Name

Social Security #

United States (see code list for other countries)

Your Medical School

University of Wisconsin Hospital and Clinics
Madison, WI
Program Director

Attn: IMG’s

Page 1 of 3
### COUNTRY CODE LIST (continued)

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<td>Rwanda</td>
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<td>Reunion</td>
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<td>Somalia</td>
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<td>St. Vincent and The Grenadines</td>
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### GRADUATE MEDICAL EDUCATION PROGRAM CODE LIST (ALPHABETICAL)

**Use only for item 9.**

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<td>Dermatology</td>
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<tr>
<td>Emergency Medicine</td>
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<tr>
<td>Family Practice</td>
<td>20</td>
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<tr>
<td>Internal Medicine</td>
<td>16</td>
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<tr>
<td>Medicine – Pediatrics</td>
<td>30</td>
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<tr>
<td>Neurological Surgery</td>
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<td>Pediatrics</td>
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<td>Nuclear Medicine</td>
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<td>Ophthalmology</td>
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<tr>
<td>Orthopedic Surgery</td>
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<td>Obstetrics/Gynecology</td>
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<td>Physical Medicine &amp; Rehabilitation</td>
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<td>Public Health</td>
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<td>Psychiatry</td>
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<td>Radiology – Therapeutic</td>
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### SPECIALTY CODE LIST (ALPHABETICAL)

**Use only for item 10.**

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<tr>
<td>Anesthesiology</td>
<td>02</td>
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<td>Colorectal Surgery</td>
<td>05</td>
</tr>
<tr>
<td>Dermatology</td>
<td>04</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>03</td>
</tr>
<tr>
<td>Family Practice</td>
<td>06</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>07</td>
</tr>
<tr>
<td>Medical Genetics</td>
<td>01</td>
</tr>
<tr>
<td>Neurological Surgery</td>
<td>08</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
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<tr>
<td>Ophthalmology</td>
<td>12</td>
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<tr>
<td>Osteopathic Surgery</td>
<td>13</td>
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<tr>
<td>Otolaryngology &amp; Oropharyngology</td>
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<tr>
<td>Orthopedic Surgery</td>
<td>13</td>
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<tr>
<td>Preventive Medicine</td>
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<tr>
<td>Psychiatry</td>
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<td>Radiology</td>
<td>21</td>
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<td>Surgery</td>
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<td>Thoracic Surgery</td>
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### OSTEOPATHIC (DO) SPECIALTY CODES (ALPHABETICAL)

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<td>Internal Medicine</td>
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<td>35</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>36</td>
</tr>
<tr>
<td>Preventive Medicine</td>
<td>37</td>
</tr>
<tr>
<td>Radiology</td>
<td>38</td>
</tr>
<tr>
<td>Rehabilitation Medicine</td>
<td>40</td>
</tr>
<tr>
<td>Surgery</td>
<td>41</td>
</tr>
</tbody>
</table>
10. SPECIALTY
See instructions for Specialty Code. Use appropriate specialty and/or subspecialty code.

11. USMLE OR ECFMG IDENTIFICATION NUMBER
Identification Number (If Known)
ECFMG: 0-000-000-0
USMLE: 0-000-000-0

12. ADDRESS
Home Mailing Address
- Address Line 1
- Address Line 2
City: [Enter City]
State: [Enter State Code]
USA: [Enter USA Code]
Zip Code: [Enter Zip Code]

Coordinator’s Phone number

Your Email Address

13. TEST ACCOMMODATIONS
Check this box if you are requesting test accommodations.

14. DATA RELEASE
Release of Step 3 Data

15. RACE/ETHNIC DATA
Select the one option which best describes your race/ethnicity.
- [ ] American Indian or Alaskan Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] Hispanic or Latino
- [ ] Other (please specify) [ ]

Is English your native language?
- [ ] Yes
- [ ] No

Response Optional
Provide your USMLE number

Paste your 2” X 2” Photo in space provided

This form must be notarized

If applicable attach name change documentation

Include in the small manila envelope

DRL
**SEND ONLY THE PROPERLY COMPLETED STEP 3 APPLICATION, DOCUMENTS AND PHOTO ID PAGE TO THE WISCONSIN BOARD**

This fee form and fee ONLY should be sent to the Federation of State Medical Boards at the address below. Attach this form to your personal check, cashier’s check or money order for $705 for Step 3 and mail via first class mail only to:

Federation of State Medical Boards
Attn: Wholesale Lockbox
P.O. Box 970172
Dallas, Texas 75397

Please Note: The USMLE Step 3 maintains a “No Refund” policy.

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle name</th>
<th>mm/dd/yyyy</th>
</tr>
</thead>
<tbody>
<tr>
<td>000-00-0000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical School Name</th>
<th>MD or DO</th>
<th>Graduation Date</th>
<th>Home phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-000-000-0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>USMLE ID NUMBER</th>
<th>Home Address</th>
<th>Apartment Number</th>
<th>Phone Number (with AREA CODE)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS (Street Address)</th>
<th>(City, State, Zip Code)</th>
<th>Email Address</th>
<th>EMAIL ADDRESS (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Beginning September 2009, The USMLE Practice exam CD-ROM is no longer be available. Practice exam material can be found and downloaded from the USMLE website at www.usmle.org.

Form S3-08-WI

Complete form and turn into the GME Staff

A check for $705 for Step 3 will be required by you in Spring 2010 –

Once your USMLE application has been sent to the FSMB by the DRL, the GME Office will notify you to bring the check to GME Office so it can be included with this Fee Form.

Step 3 applications are normally sent the first week of May if all licensing requirements are met.
EBAHR  
Page 1 of 2

**Complete if you:**  
✓ Are applying to take Step 3 in Wisconsin.  
✓ Passed Step 3  

Ignore if you will be using COMLEX for licensing

---

**SECTION I - Personal Information**

<table>
<thead>
<tr>
<th>Last Name/Surname</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Alternate/Previous Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBAHR</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Home Address**  
City State Zip:  
Phone:  
Email:  

**U.S. Social Security Number**  
**SSN#**

**Country of Citizenship upon entering medical school**  
United States

**Medical School Name, City & Country**

**Graduation Date (Mo/Year)**  
**Grad Date (MM YYY)**

**Sex:**
- Male [ ]
- Female [ ]

**ECFMG Number**

---

**Attn:**

**IMGs**

---

**SECTION II - Calculation of Required Payment**

(The EBAHR fee is $50 payable to the Federation of State Medical Boards via check or money order.)

Number of Parties (listed in Section IV, Part B) to which an EBAHR is to be sent. You may request up to two (2) EBAHRs for each $50 fee. 1-2/$50 3-4/$100 5-6/$150, etc. $50

Number of EBAHRs to be sent Express ($16 per each address).  

<table>
<thead>
<tr>
<th>Number of EBAHRs</th>
<th>Cost per EBAHR</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$16</td>
<td>$50</td>
</tr>
</tbody>
</table>

Total Payment Required = $50
Since your $50 covers two reports, you might want to have the second one sent to you.
**Licensing Session**

Here is where you will find your user name and password to take the Statutes Exam.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Medicine and Surgery, MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Fitchburg, WI</td>
</tr>
<tr>
<td>Application Status</td>
<td>Pending (In process)</td>
</tr>
</tbody>
</table>

**Requirements Not Met:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>WI Statute &amp; Rules Examination Booklet &amp; Answer Sheet</td>
<td>Open book exam is on our website. When you're at the ParTest Online you will need the following info: Instructor: dft Test Name: MED07A Test Password: MED07A Student ID: 29525</td>
</tr>
<tr>
<td>USMLE Step 3 score (after exam)</td>
<td></td>
</tr>
<tr>
<td>USMLE application received</td>
<td>2008 application deadline has passed, 2009 application mailed 9/26/08</td>
</tr>
<tr>
<td>USMLE application mailed to FSMB</td>
<td></td>
</tr>
<tr>
<td>Certificate of Post-Graduate Training (Form #2165) Need after passing Step 3</td>
<td>Need after you complete 1st year &amp; pass Step 3 UW Hosp &amp; Clinics</td>
</tr>
<tr>
<td>Oral exam to be determined after passing Step 3</td>
<td></td>
</tr>
</tbody>
</table>
Wisconsin Statutes and Rules Examination

- Open book exam is taken online. You can stop and start the exam as often as you like. It will take up to 2-6 hours to complete.

- 20% of residents will fail the first time. Take your time.

- If you fail the exam, there is a fee of $57 to reset the exam.
### Requirements Not Met:

<table>
<thead>
<tr>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>USMLE Step 3 score (after exam)</td>
<td></td>
</tr>
<tr>
<td>Certificate of Post-Graduate Training (Form #2165) Need after passing Step 3</td>
<td>Need after you complete 1st year &amp; pass Step 3 UW Hosp &amp; Clinics</td>
</tr>
<tr>
<td>Oral exam to be determined after passing Step 3</td>
<td></td>
</tr>
</tbody>
</table>

### Requirements Met:

<table>
<thead>
<tr>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Fee</td>
<td>PAID 11/9/07</td>
</tr>
<tr>
<td>Affidavit of applicant, signed and notarized</td>
<td></td>
</tr>
<tr>
<td>Pre-Professional and Professional Education</td>
<td></td>
</tr>
<tr>
<td>Pages One and Two - Applicable blanks completed</td>
<td></td>
</tr>
<tr>
<td>Pages Three, Four and Five - Applicable blanks completed</td>
<td></td>
</tr>
<tr>
<td>Authorization and Waiver, signed and notarized</td>
<td></td>
</tr>
<tr>
<td>Copy of Medical diploma</td>
<td></td>
</tr>
<tr>
<td>Social Security Number Collection Form (#2380)</td>
<td></td>
</tr>
<tr>
<td>WI Statute &amp; Rules Examination Booklet &amp; Answer Sheet</td>
<td></td>
</tr>
<tr>
<td>All activities and practice accounted for</td>
<td></td>
</tr>
<tr>
<td>Medical Education Verification Form (#2164)</td>
<td>Graduated 5/07</td>
</tr>
<tr>
<td>USMLE application received</td>
<td></td>
</tr>
<tr>
<td>USMLE application mailed to FSMB</td>
<td>Mailed 7/11/08</td>
</tr>
<tr>
<td>USMLE Step 1, Step 2 scores</td>
<td></td>
</tr>
</tbody>
</table>

This must indicate you **passed** prior to Step 3 application being forward to FSMB.

Send in fee form and check for $705.
For residents who are taking Step 3 out of Wisconsin or have already passed Step 3, you will need to complete the AMA Profile.

Cost: Free for AMA Members
     $31 for Non-AMA Members
If you are applying to take COMLEX Part 3 follow the directions at http://www.nbome.org to register online.
How to monitor your license application progress

- We recommend that you check the DRL website weekly to monitor your application status.
- Keep in mind it may take the DRL 2-3 weeks to update your application status.
- http://drl.wi.gov/index.htm
DRL small manila envelope

- Application for Full License (Form 570)
  Diploma and $147 or $132 check
- Work History (Form 1934)
- Malpractice Suits or Claims (Form 2829)
- Hospital Verification only if N/A indicated (Form 2167)
- Authorization and Waiver (w/ notarized signature - Form 571)
- USMLE Step 3 Application (notarized & photo)

If applicable:
Convictions or Pending Charges (Form 2252)