

# Wisconsin Department of Safety and Professional Services

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Madison, WI 53708-8935  
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**Ship To:** 1400 E. Washington Avenue  
Madison, WI 53703  
**E-Mail:** [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
**Website:** <http://dsps.wi.gov>

## PODIATRY AFFILIATED CREDENTIALING BOARD

### INFORMATION FOR COMPLETING LICENSE TO PRACTICE PODIATRIC MEDICINE AND SURGERY

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

1. **National Board Scores** Original score reports must be submitted directly from the testing agency. Both passing and failing scores are required. Copies sent from applicant, photocopies, online verifications, or faxes are not acceptable. Please request the testing agency mail your scores directly to DSPS, Attn: Podiatry Affiliated Credentialing Board, P.O. Box 8935, Madison, WI 53708-8935, email scores directly to [DSpscMedBdAffiliates@wi.gov](mailto:DSpscMedBdAffiliates@wi.gov) or fax with agency cover sheet/letter to 608-261-7083.
2. **Certificate of Professional Education (Form #1921)**
3. **Certificate of Postgraduate Training (Form #2480)**
4. **Verification of Licensure in Other State(s)** Please contact each state board you have ever held or current hold a podiatry license in and request verification of licensure be submitted directly to our Department. State Boards may email the verification directly to [DSpscMedBdAffiliates@wi.gov](mailto:DSpscMedBdAffiliates@wi.gov) or fax with agency cover sheet/letter to 608-261-7083.
5. **Examination on Wisconsin Law** An applicant shall successfully complete an online examination on Wisconsin Statutes and Rules relating to the practice of podiatry before a license can be issued in Wisconsin. Information for the online examination will be provided after an application for licensure has been received at DSPS.

Applicants **may** be required to complete an oral examination per Wis. Admin. Code § POD 1.06(1). If selected to appear for an oral examination, the applicant will be advised of the date upon completion of their application.

#### **MALPRACTICE LIABILITY INSURANCE COVERAGE FOR PODIATRISTS:**

Per Wis. Stat. § 448.655 a licensed podiatrist shall annually submit to the board evidence that the podiatrist has in effect malpractice liability insurance coverage in the amount of at least \$1,000,000 per occurrence and \$1,000,000 for all occurrences in one year or file an exemption under conditions stated below.

A copy of certificate of insurance showing limits of liability coverage and dates of coverage must be submitted to the Podiatry Affiliated Credentialing Board at the address listed above.

After you have been issued a WI Podiatry License, please send a copy of your Certificate of Insurance to our Department or if you qualify for an exemption, complete ([Form #2700](#)) and submit to our Department.

**The Board may suspend, revoke or refuse to issue or renew the license of a podiatrist who fails to procure or to submit proof of the malpractice liability insurance coverage required under Wis. Stat. § 448.655(3).**



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

- |  |   |
|--|---|
| <input type="checkbox"/> Application ( <b>Form #575</b> ) and appropriate fee<br><input type="checkbox"/> Certificate of Professional Education ( <b>Form #1921</b> )<br><input type="checkbox"/> Certificate of Postgraduate Training ( <b>Form #2480</b> )<br><input type="checkbox"/> National Examination Scores (sent directly from the National Board)<br><input type="checkbox"/> Letters from all State Boards where licensed, active and inactive | <input type="checkbox"/> Convictions and Pending Charges ( <b>Form #2252</b> ), if applicable<br><input type="checkbox"/> Malpractice Suits or Claims ( <b>Form #2829</b> ) and copies of malpractice suit, court documents with allegations and settlement, if applicable<br><input type="checkbox"/> Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc. |
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**ARE YOU A VETERAN?** If yes, please view the Department website at <http://dsps.wi.gov> under "License, Permits, and Registrations" and select "Military Benefits Related to Licensure for Eligible Veterans Services Members and Spouses" for eligibility requirements.

**If you qualify, are you requesting a waiver of your initial credentialing fee?**  Yes  No

If Yes, provide a copy of your Department of Veterans Affairs voucher code and list your DVA Voucher Code Number:

**If you qualify, are you requesting equivalency of your Military Training and experience?**  Yes  No

If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

**If you qualify, are you requesting Temporary Spousal Reciprocal License?**  Yes  No

If Yes, do not complete this form. You must complete and return the Application for Temporary Spousal Reciprocal License (**Form #2982**).

**You may contact the DVA at 1-800-WisVets or [www.WISVETS.com](http://www.WISVETS.com) for assistance in obtaining your DVA Voucher Code and/or documents related to your training.**

**CONTINUING EDUCATION AND RENEWAL REQUIREMENTS:** Please view the Department website at <http://dsps.wi.gov> and select the "Professional Credential Renewal Information".

**POST-GRADUATE TRAINING:** Account for all post-graduate training activities.

Post-Graduate Training Facility	Location of Facility (City/State)	Dates of Training (Month/Year)
<input style="width: 100%; height: 100%;" type="text"/>	(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 30px; height: 20px;" type="text"/>	(From) <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/> (To) <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/>
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**EXPERIENCE AND PRACTICE:** Outline in chronological order all activities from the date of graduation from podiatric school to the present time. Must include professional and nonprofessional activities. All time and dates must be accounted for.

Employer Name	Location of Employment (City/State)	Dates of Employment (Month/Year)	The Position in which you are/were Employed
	(City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	
	(City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	
	(City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	
	(City) <input style="width: 100%;" type="text"/> (State) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	(From) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> (To) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	

**I AM OR HAVE BEEN LICENSED IN THE FOLLOWING STATE(S):** (include all active and inactive states)

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For each credential listed above, you are required to have each State Board or territory of the United States submit a letter of verification to the Wisconsin Podiatry Affiliated Credentialing Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

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**ANSWER THE FOLLOWING QUESTIONS:** (attach additional sheet(s) if necessary)

1.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? <b>If yes, give details on an attached sheet, including the name of the profession and the agency.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever failed to pass any state board examination, national board examination? If yes, provide details below: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	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, or revocation? <b>If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Is disciplinary action pending against you in any jurisdiction? <b>If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. <b>If yes, submit Convictions and Pending Charges (Form #2252).</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Are you incarcerated, on probation, or on parole for any conviction? <b>If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have any suits or claims ever been filed against you as a result of professional services? <b>If yes, Malpractice Suits or Claims (Form #2829).</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Are you registered or licensed in any other profession(s)? <b>If yes, state what profession(s) and in what state(s):</b> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you ever been credentialed under any other name(s)? <b>If yes, state name(s) credentialed under:</b> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? <b>If yes, give details on an attached sheet.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned podiatry judgments and to learn and keep abreast of podiatry developments; and
2. The ability to communicate those judgments and podiatric 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.

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**ANSWER THE FOLLOWING QUESTIONS:** (attach additional sheet(s) if necessary)

11.	Do you have a medical condition, which in any way impairs or limits your ability to practice dentistry with reasonable skill and safety? If no, you may skip questions 12 and 13. <b>If yes, please explain.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	If yes to question 11, 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? <b>If yes, please explain.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	If yes to question 11, 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? <b>If yes, please explain.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice dentistry with reasonable skill and safety? <b>If yes, please explain.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? <b>If yes, please explain.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	If yes to question 16, 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? <b>If yes, please explain.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**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.

Signature: \_\_\_\_\_ Date:   /   /