MILITARY MEDICAL PERSONNEL PROGRAM LICENSURE TIMELINE

This document, Military Medical Personnel Timeline to Licensure, must be submitted to DSPS prior to performing any activity listed in the Memorandum of Understanding: Wisconsin Department of Safety and Professional Services (DSPS), P.O. Box 8935, Madison, WI 53708-8935 or dsps@wisconsin.gov.

PLEASE TYPE OR PRINT IN INK	☐ Your name, address, phone number, and email address are available to the public. Check box to withhold street address/PO Box, phone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).			
Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**	
Address (number/street)	(city)	(state)	(zip code)	**Daytime Phone Number**
				☐☐☐-☐☐☐-☐☐☐☐
Mailing Address (if different) (number/street)	(city)	(state)	(zip code)	**Date of Birth**
				☐☐/☐☐/☐☐☐☐

Social Security Number ☐☐☐-☐☐-☐☐☐☐

Your Social Security Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form 1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Ethnicity/gender status information is optional.

GENDER: ☐ M ☐ F

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

Email Address

Have you ever been licensed as a healthcare professional in Wisconsin? ☐Yes ☐ No — If yes, list profession and credential #

Profession — #

1. Have you served as an Army Medic, a Navy or Coast Guard Corpsman, or an Air Force Aerospace Medical Technician in the U.S. Armed Forces? **If YES, identify your type of service ☐ an Army Medic, ☐ a Navy or Coast Guard Corpsman, or ☐ an Air Force Aerospace Medical Technician. If NO, you do not qualify for the MMP Program.** ☐ Yes ☐ No

2. Have you been discharged or released from the service identified in Question 1 in the previous 12 months under honorable or general conditions? **If YES,** ☐ Yes ☐ No
   - provide discharge/release date ☐☐/☐☐/☐☐☐☐ and
   - attach proof of military service and general or honorable discharge.

   If NO, you do not qualify for the MMP Program.

3. **Name of Healthcare Institution in MOU** | **Healthcare Institution Contact**

   Address (number/street) | (city) | (state) | (zip code)

   Institution Contact Email Address | **Institution Contact Phone Number** ☐☐☐-☐☐☐-☐☐☐☐

4. **TYPE OF CREDENTIAL SOUGHT WITH TIMELINE** (Check one)**:**

☐ **Anesthesiologist Assistant**	☐ **Physician Assistant**	☐ **Nurse, Licensed Practical (LPN)**
☐ **Perfusionist**	☐ **Podiatrist**	☐ **Nurse, Registered (RN)**
☐ **Physician** (select) ☐ **MD** ☐ **DO**	☐ **Respiratory Care Practitioner**	

5.	STEPS TO LICENSURE (to be established with your employer)		Goal for Completion (or N/A - Not Applicable)
	a.	**Application submission and fee(s) (REQUIRED)**	__/__/____
	b.	**Completion of all necessary education, if applicable**	__/__/____ ☐ N/A
	c.	**Completion of all training, if applicable**	__/__/____ ☐ N/A
	d.	**Successful passage of required exam(s), if applicable**	__/__/____ ☐ N/A
	e.	**Receipt of national certification, if applicable**	__/__/____ ☐ N/A
	f.	**Submission of all required application-related documentation (REQUIRED)**	__/__/____
	g.	**Other:**	__/__/____
	h.	**Other:**	__/__/____
	i.	**Other:**	__/__/____
	j.	**Other:**	__/__/____

6.	**DATE ON WHICH MMP AGREES TO ACQUIRE LICENSURE (REQUIRED)**	__/__/____
	• **AN MMP Program Participant becomes ineligible to participate in the program beginning on the day after the date that the MMP agreed to acquire a license.** • The Medical Examining Board may extend the termination date of a signed memorandum of understanding if it appears that, because of unforeseen circumstances, the applicant requires more time to receive a license. Submit narrative request to Wisconsin Department of Safety and Professional Services, Attn: Medical Examining Board, P.O. Box 8935, Madison, WI 53708-8935 or dsps@wisconsin.gov.	

MMP ATTESTATION: I declare that I am the person referred to on this form and that all information required to be completed by me (the MMP), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that the form was completed with personnel from the facility listed in Military Medical Personnel Memorandum of Understanding (MOU). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with this submitted form or my required related application for 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. By signing below, I am signifying that I have read and understand the above declarations.

MMP Signature (If unable to provide a digital signature print and sign form.)	**Date**
	__/__/____