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| DEPARTMENT OF HEALTH SERVICES Division of Medicaid Services  F-00154 (06/2019) | | STATE OF WISCONSIN Disability Determination Bureau | | | |
| WISCONSIN CONSULTATIVE EXAMINATION INQUIRY | | | | | |
| **INSTRUCTIONS:** Complete this form. Save and attach it to an email, and send it to [dhswebmaildhcf@wisconsin.gov](mailto:dhswebmaildhcf@wisconsin.gov). If you are unable to email it, print and mail the completed form to:  Disability Determination Bureau  Attn: Professional Relations Officer  PO Box 7886  Madison, WI 53707-7886 This information is being collected to recruit health professionals to perform consultative examinations for the Disability Determination Bureau (DDB). Personally identifiable information requested on this form will be used by DDB for consultative examination recruitment purposes only. | | | | | |
| Name – (Last, First MI) | | | | Phone Number (including area code) | |
| Email Address | | | | Fax Number (including area code) | |
| Do you have a Wisconsin license?  Yes  No | If Yes – License Number | | | Expiration Date | |
| Do you have a license in other states?  Yes  No | If Yes – provide state, license number, and expiration date below. | | | | |
| State | | License Number | | Expiration Date |
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| Are you a board-certified physician?  Yes  No | If yes, what specialty(ies) | | | | |
| What age bracket have you seen in the past? (Check all that apply.)  Infants (birth to 1)  Child (2 to 5)  Child (6 to 12)  Adolescent (13 to 17)  Adults (over 18) | | | | | |
| Comments | | | | | |