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| DEPARTMENT OF HEALTH SERVICESDivision of Medicaid ServicesF-00154 (06/2019) | STATE OF WISCONSINDisability Determination Bureau |
| WISCONSIN CONSULTATIVE EXAMINATION INQUIRY |
| **INSTRUCTIONS:** Complete this form. Save and attach it to an email, and send it to dhswebmaildhcf@wisconsin.gov. If you are unable to email it, print and mail the completed form to:Disability Determination BureauAttn: Professional Relations OfficerPO Box 7886Madison, WI 53707-7886This 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      |