Wisconsin Department of Safety and Professional Services

Health & Business Renewal Application

Application Status Query

Instructions:

Please allow one hour after receipt of your status update email for the updates to be reflected in the online checklist.

Please verify the checklist information below, including your address. If your address has changed, please e-mail your application number, name, profession, along with your old and new address. The Credentialing department posts status information following receipt and review of application materials. Please note that we receive an average of 13,280 applications and renewals per month. Depending on the volume received, it may take up to three (3) weeks for the status of your requirements to be updated.

As of : 07/20/2020
Application# : 725658
Name : Wenzel, Luke R
Profession : Medicine and Surgery, DO
Address : La Crosse, WI
Application Status : (Permanent license issued)

Requirements Not Met:

Description	Status	Comments (Please note, not all requirements will include comments)

Requirements Met:

Description	Status	Comments (Please note, not all requirements will include comments)
Application Fee	Met	$75
Application Complete	Met	
All activities and practice	Met	

accounted for		
All questions answered and relevant copies attached	Met	
Certification of Legal Status Completed	Met	
Affidavit of applicant, signed	Met	
Authorization and Waiver, signed (Form #571)	Met	
National Board Scores, original certification	Met	
Physicians Profile Data Report from AOA or AMA	Met	Report date: 07/10/2020 -AK
Physician Data Center Practitioner Profile Report (Form #1445)	Met	
Medical Education Verification Form (Form #2164)	Met	Des Moines 05/28/2016
Certificate of	Met	Nebraska 07/16-06/20

Post-Graduate Training (Form #2165)		
Hospital, Facility, and Employer Verification (Form #2167)	Met	Bellvue 07/19-06/20
Verification of state license(s) directly from State Board office(s)	Met	NE
National Practitioner Data Bank Report/Self-query response	Met	

Send Questions or Comments to dsps@wisconsin.gov

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. § § 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK

☒ Your name, address, telephone number, and email address are available to the public. Check box to withhold address, telephone 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)
WENZEL	LUKE	R	

Address (street, city, state, zip): [redacted] OMAHA, NE, 68114

Daytime Telephone Number: [redacted]

Mailing Address (if different):

Date of Birth: [redacted]

Social Security #: [redacted]

Your Social Security Number or Employer Identification 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.

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

Sex: ☒ M ☐ F

Have you ever been licensed in Wisconsin as a Physician? ☐ Yes ☒ No If yes, list your credential number:

Email Address: [redacted]

Specialty (see page iv for a listing of codes): Obstetrics and Gynecology

Specialty Code (see page iv for a listing of codes): 112

Medical School: Des Moines University

Medical School Address (street, city, state):

Degree: Doctor of Osteopathy

Please check one: ☐ MD ☒ DO

Date Degree Granted: 05/28/2016

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

☐ Please check this box if you are applying for Administrative Physician Licensure

- ☐ I am seeking a Veteran Fee Waiver (for Initial Credential Fee only, see page 2 for further information)
- ☐ Endorsement of Steps 1, 2 and 3 of USMLE
  S75.00 Initial Credential Fee
  S75.00 Total Fee Attached
- ☒ Endorsement of National Boards (MD or DO), (NBME or NBOME)
  S75.00 Initial Credential Fee
  S75.00 Total Fee Attached
- ☐ Endorsement of FLEX
  S75.00 Initial Credential Fee
  S75.00 Total Fee Attached
- ☐ Endorsement of LMCC (taken after 1/1/78)
  S75.00 Initial Credential Fee
  S75.00 Total Fee Attached
- ☐ Reciprocity of State Board Exam (Taken Prior to 1972)
  S75.00 Reciprocal Credential Fee
  S75.00 Total Fee Attached
- ☐ Visiting Physician
  S59.00 Reciprocal Credential Fee
  S59.00 Total Fee Attached
- ☐ Re-Registration (license expired more than 5 years)
  S 75.00 Renewal Fee
  S 25.00 Late Renewal Fee
  S100.00 Total Fee Attached

For Receipting Use Only (20/21/220/221/876)

Trn# 30377 05/11/2020 02:24 PM
CHECK
021JOF (128) 75.00
TOTAL 75.00

Wisconsin Department of Safety and Professional Services

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

- Application (**Form #570**) and appropriate fee
- Physician Profile Data Report from the American Medical Association or American Osteopathic Association
- Copy of ECFMG Certificate if a Foreign Graduate (FCVS), **not applicable for Re-Registration**
- Joint Commission Certified Hospital, Facility, and Employer Verification (**Form #3046**), **if applicable**
- Medical Education Verification Form (**Form #2164**) (FCVS), **not applicable for Re-Registration**
- Signed Authorization and Waiver Form (**Form #571**)
- Letters from all State Boards where licensed, **active and inactive**
- National Board, FLEX, State Board, USMLE or LMCC score (FCVS), **not applicable for Re-Registration**
- Certificate of Post-graduate Training (**Form #2165**) (FCVS), **not applicable for Re-Registration**
- Proof of 30 hours of CE completed in the previous biennium (**Re-Registration applicants**)
- Convictions and Pending Charges (**Form #2252**), **if applicable**
- Malpractice Suits or Claims (**Form #2829**) and copies of malpractice suit, court documents with allegations and settlement, **if applicable**
- Physician Data Center Practitioner Profile Report from the Federation of State Medical Boards (**Form #1445**), (FCVS)
- Hospital, Facility and Employer Verification (**Form #2167**)
- Copy of a license to practice medicine and surgery in another state or Canada and a letter of good standing, **only required for Visiting Physician**
- National Practitioner Data Bank Report
- Signed Letter from the President or Dean of a medical school, facility, or college in Wisconsin indicating that the applicant intends to teach, research, or practice medicine and surgery at a medical education facility, medical research facility, or medical college in this State as a Visiting Physician, **only required for Visiting Physician**
- Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc.

ARE YOU A VETERAN? If yes, please view the Department website at https://dsps.wi.gov/Pages/Professions/MilitaryLicensureBenefits.aspx 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 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 https://dsps.wi.gov/Pages/Professions/Physician/Default.aspx.

POST-GRADUATE TRAINING/FELLOWSHIPS, PRACTICE, AND OTHER ACTIVITIES: List in chronological order from the date of graduation of medical school to the present time. The below information must include professional and nonprofessional activities. **(Attach additional sheets if necessary using the same format.)**

For all hospitals, facilities and employers where you are or have been employed, had or held staff privileges or appointments for five years preceding the date of application, the Hospital, Facility and Employer Verification form (**Form #2167**) must be submitted.

Please Note: The dates provided on this application must match the dates provided on the verification provided by the facility. Discrepancies will cause delays in the application process.

DATES (Month, Year)	TYPE	NAME OF SCHOOL, HOSPITAL CLINIC OR OTHER	LOCATION (City, State and Country)
(From) 07/16 (To) 06/20	☐ Intern ☒ Resident ☐ Fellow ☐ Practice ☐ Other	University of Nebraska Medical Center	(City) Omaha (State) NE (Country) USA
(From) 07/19 (To) 06/20	☐ Intern ☐ Resident ☐ Fellow ☒ Practice ☐ Other	Bellevue Health Clinic	(City) Bellevue (State) NE (Country) USA
(From) __/__ (To) __/__	☐ Intern ☐ Resident ☐ Fellow ☐ Practice ☐ Other		(City) (State) (Country)

Wisconsin Department of Safety and Professional Services

POST-GRADUATE TRAINING/FELLOWSHIPS, PRACTICE, AND OTHER ACTIVITIES, continued...

DATES (Month, Year)	TYPE	NAME OF SCHOOL, HOSPITAL CLINIC OR OTHER	LOCATION (City, State and Country)
(From) __/__ (To) __/__	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) __/__ (To) __/__	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) __/__ (To) __/__	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) __/__ (To) __/__	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) __/__ (To) __/__	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) __/__ (To) __/__	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)
(From) __/__ (To) __/__	☐Intern ☐Resident ☐Fellow ☐Practice ☐Other		(City) (State) (Country)

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

NE | __ | __ | __ | __ | __ | __ | __ | __ | __ | __ | __ | __

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 Medical Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

Wisconsin Department of Safety and Professional Services

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

1.	Are you registered or licensed in any other profession(s)? **If yes, state what profession(s) and in what state(s):**	☐ Yes ☒ No
2.	Have you ever been credentialed under any other name(s)? **If yes, state name(s) credentialed under:**	☐ Yes ☒ No
3.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health regarding communicable diseases? https://docs.legis.wisconsin.gov/code/admin_code/dhs/110/145 https://docs.legis.wisconsin.gov/statutes/statutes/252	☒ Yes ☐ No
4.	Have you ever failed to pass any state board examination, national board examination (NBME or NBOME), FLEX, or USMLE examination? **If yes, provide details below:**	☐ Yes ☒ No
5.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? **If yes, give details on an attached sheet, including the name of the profession and the agency.**	☐ Yes ☒ No
6.	Is disciplinary action pending against you in any jurisdiction? **If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.**	☐ Yes ☒ No
7.	Have you ever been reprimanded, demoted, disciplined, cautioned, placed on probation, limited in your practice or privileges, placed on or taken leave greater than 90 days, or terminated by any employer, educational institution, training program, licensing board, hospital, medical facility, professional society, specialty board, or medical body for any reason? **If yes, attach a sheet providing details about the action, including the name of the entity and date of action.**	☐ Yes ☒ No
8.	Have any suits or claims ever been filed against you as a result of professional services? **If yes, Malpractice Suits or Claims (Form #2829).**	☐ Yes ☒ No
9.	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.**	☐ Yes ☒ No
10.	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. **If yes, submit Convictions and Pending Charges (Form #2252).**	☐ Yes ☒ No
11.	Are you incarcerated, on probation, or on parole for any conviction? **If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.**	☐ Yes ☒ No
12.	If yes to question 10 above, did you apply for a predetermination of the convictions? **If YES, proceed to question 13.** **If NO, submit Convictions and Pending Charges Form #2252 and supporting documentation.**	☐ Yes ☐ No
13.	If yes to question 12, did you receive an approval letter? **If YES, proceed to question 14.** **If NO, you may proceed to question 15.**	☐ Yes ☐ No
14.	If yes to question 14, **since the date of your approval letter** have you 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. **If YES, submit Convictions and Pending Charges Form #2252 and supporting documentation.** **If NO, do not submit Convictions and Pending Charges Form #2252.**	☐ Yes ☐ No

Wisconsin Department of Safety and Professional Services

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 direction of a licensed health care practitioner.

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

15.	Do you have a medical, physical, or mental condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If no, you may skip questions 17. **If yes, please explain.**	☐ Yes ☒ No
16.	If yes to question 15, are the limitations or impairments caused by your medical, physical or mental condition reduced or ameliorated because you receive ongoing treatment (with or without medications), participate in a monitoring program or 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.**	☐ Yes ☐ No
17.	Do you use chemical substance(s), as defined above, that in any way impair, or limit your ability to practice medicine with reasonable skill and safety? **If yes, please explain.**	☐ Yes ☒ No
18.	Are you currently (within the last two years) engaged in the illegal use of controlled dangerous substances?	☐ Yes ☒ No
19.	If yes to question 18, are you 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.**	☐ Yes ☐ No
20.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **If yes, please explain.**	☐ Yes ☒ 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.

Wisconsin Department of Safety and Professional Services

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: 01/04/2020

Wisconsin Department of Safety and Professional Services

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

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4822 Madison Yards Way
Madison, WI 53705

E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

AUTHORIZATION AND WAIVER

Applicant: Please complete and forward this form to all sources that verify information directly to the Wisconsin Medical Examining Board (**example: verification of hospital privileges**). Provide a copy of this completed form when submitting your application materials to DSPS.

Last Name: WENZEL

First Name: LUKE

Middle Initial: R

Former/Maiden Name(s):

Date of Birth: [redacted]

City/State/Country of Birth: [redacted] / Wisconsin / USA

Having filed an application for a license to practice medicine and surgery in the State of Wisconsin, I 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, and 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.

Applicant Signature Luke Wenzel Date 05/04/20

COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION - USA

Official Transcript

Wisconsin Medical Examining Board
P.O. Box 8935
Madison, WI 53708

Examinee: Wenzel, Luke Richard
NBOME ID: [redacted] **Date of Birth:** [redacted]

EXAMINATION	DATE COMPLETED	PASS / FAIL	3 - DIGIT STANDARD SCORE	3 - DIGIT MINIMUM PASSING	2 - DIGIT STANDARD SCORE	2 - DIGIT MINIMUM PASSING	NOTE
Level 1							
	15-Jul-2014	Pass	611	400	--		
Level 2 Cognitive Evaluation (CE)							
	20-Jul-2015	Pass	629	400	--		
Level 2 Performance Evaluation (PE)							
	07-Jul-2015	Pass	Not Applicable		Not Applicable		
Level 3							
	10-Apr-2017	Pass	668	350	--		

The National Board of Osteopathic Medical Examiners, Inc., does hereby certify the above to be a true report of the examinee.

Date Prepared: May 05, 2020

[redacted]

-- please see reverse for information and description of notes -- v3.0

National Board of Osteopathic Medical Examiners, Inc.
8765 West Higgins Road Suite 200 Chicago IL 60631-4174
Phone: 773/714-0622 Fax: 773/714-0631

COMLEX-USA Score Interpretation

COMLEX-USA is the series of examinations used by the state medical and osteopathic medical boards for the licensure of osteopathic physicians in the United States. It consists of three levels: Level 1, Level 2-Cognitive Evaluation (CE) and Level 2-Performance Evaluation (PE), and Level 3*. The COMLEX-USA Level 2-PE is a clinical skills examination with a Pass/Fail scoring format. The scores reported for the COMLEX-USA computer-based cognitive examinations are 3-digit standard scores for Levels 1, 2-CE and 3.

The COMLEX-USA Percentile Score Conversion tool converts 3-digit standard scores to percentile scores and is available on the NBOME website www.nbome.org .

The NBOME cautions residency program directors to avoid the sole use of any examination score, or the overuse or sole use of any examination program, in screening or hiring residents, and supports holistic admissions reviews.

COMLEX-USA Level 1, 2-CE, 3

Standard scores (3-digit): the 3-digit score is a standard score, derived from the number of items or key features answered correctly in the entire examination. The mean of the 3-digit standard score for computer-based cognitive examinations has historically been in the 500-550 range with the standard deviation in the 80 to 125 range. Most candidates receive a score between 200 and 800. The minimum passing 3-digit standard score for Level 1 and Level 2-CE is 400, and for Level 3 is 350, regardless of when the examination was taken. The minimum passing 3-digit standard score for COMLEX-USA Level 1, Level 2-CE and Level 3 is equivalent to a minimum passing 2-digit score of 75. The NBOME discontinued reporting of 2-digit standard scores for the COMLEX-USA Levels 1, 2-CE, and 3 in 2015.

COMLEX-USA Level 2-PE

The Level 2-PE examination is required for all candidates graduating in 2005 or after and for those who graduated before July 1, 2004 and did not pass Level 2-CE by June 30, 2005. Candidates graduating in 2004 who passed Level 2-CE by June 30, 2005 were not required to take Level 2-PE.

Scores for Level 2-PE are reported as PASS or FAIL as one overall score. In order to receive a passing score, candidates must perform adequately in two separate domains. These are the Humanistic Domain (doctor-patient communication, interpersonal skills, and professionalism), and the Biomedical/Biomechanical Domain (medical history-taking, physical examination, osteopathic principles and osteopathic manipulative treatment, SOAP notes, which assess synthesizing information garnered in the clinical encounter, clinical problem-solving and integrated differential diagnosis.) A passing score requires demonstration of minimum competence in fundamental clinical skills required for entry in graduate medical education.

*Part I, Part II and Part III

COMLEX-USA Level 1, Level 2-CE and Level 3 examinations replaced Part I, Part II and Part III examinations in 1998, 1997 and 1995 respectively.

The scores reported for Parts I, II and III after 1998 are 3-digit standard scores for the whole examinations. Scores reported for Parts I and II before 1987 are the minimum scaled scores (2-digit) among all the component scores of the examinations. Scores reported for Part III are scaled scores (2-digit) for the whole examination.

Standard Scores (3-digit): The standard scores for all three Part examinations are reported on a scale with a mean of 500 and a standard deviation of 100. The minimum passing score for Part I and Part II is 400. The minimum for Part III is 350.

Scaled Scores (2-digit): Scaled scores are reported on a scale with a mean of 80. The minimum passing score for Part I and II is 75 for any of the components of the examinations. The minimum passing score for Part III is 75 for the whole examination.

Score Interpretation Annotations/Notes:

I – Irregular Conduct which occurred on the part of the candidate. Candidate conduct that may be considered irregular is described under "Irregular Conduct." Candidates (including any representative the candidate has authorized in writing), Medical Licensing Agencies, candidate's medical school, and residency/fellowship program directors may obtain further information regarding this annotation by contacting the NBOME.

O – Other Condition(s) Conduct which occurred during the administration of an examination and resulted in the examination not being scored, or the examination was scored after being administered or taken by the candidate under different or unusual conditions. Authorized persons may obtain further information regarding this annotation by contacting the NBOME. Authorized persons may obtain further information regarding this annotation by contacting the NBOME.

Wisconsin Department of Safety and Professional Services

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Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

MEDICAL EDUCATION VERIFICATION FORM

(Not necessary if utilizing FCVS)

APPLICANT: **Please forward this form to your medical school.**

MEDICAL SCHOOL: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant's Name: Luke Wenzel

Social Security #: (for school use to locate your records) ___ - ___ - ____

Medical School: Des Moines University

Medical School Address: 3200 Grand Ave, Des Moines, IA 50312

		YES	NO
1.	Did this Physician attend the medical school noted above?	X	
2.	What were the applicant's dates of enrollment in this medical school? Start Date: 08/08/12 End Date: 05/28/16		
3.	Did this Physician graduate from this medical school? **If no, please attach explanation on a separate sheet.** Degree Granted: DO Date Degree Granted: 05/28/16	X	
4.	Did this Physician take a leave of absence during his/her attendance at this medical school? **If yes, please attach explanation on a separate sheet.**		X
5.	Did this Physician have a record of unexcused absences during his/her attendance at this medical school? **If yes, please attach explanation on a separate sheet.**		X
6.	Was this Physician ever disciplined or under investigation during his/her attendance at this medical school? **If yes, please attach explanation on a separate sheet and indicate if this constitutes adverse formal action.**		X
7.	Were any special requirements imposed on this Physician that were not required of all other students at his/her level of education? **If yes, please attach explanation on a separate sheet.**		X
8.	Was this Physician recommended for post-graduate training?	X	

Printed Name of Dean: Registrar Melinda Miller

Signature: Melinda Miller Date 04/13/20

Medical School, please return directly to:

DSPS
Attn: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Or you may fax/email with facility cover sheet/letter to: (608) 251-3036 or DSPSCredMedBD@wisconsin.gov.

FAX

Date:	04/27/2020 18:49:01+00:00 GMT
TO	
Fax Number:	16082513036
Name:	Wisconsin Department of Safety and Professional Services
FROM	
Fax Number:	14022914643
Name:	Office Fax
Company:	A1 Professionals
Subject:	

Notes:

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX#: (608) 251-3036
Phone #: (608) 266-2112

4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

APPLICANT: **Please forward this form to all hospitals, facilities, and employers where you have had staff privileges, employment, or appointment during the last five (5) years.**

Hospital/Facility/Employer: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name: Luke Wenzel

Name of Hospital/Facility/Employer: Bellevue Health Clinic

Hospital/Facility/Employer's Address: 1002 W Mission Ave, Bellevue, NE 68005

Hospital/Facility/Employer's Daytime Phone: 402-292-4164

Hospital/Facility/Employer, you must answer all of the following questions and provide any additional information in order for this form to be considered complete.

1. What position did this Physician hold at your facility or under your employment?

   Staff Physician

2. What were this Physician's dates of employment or staff privileges at your facility?

   07/2001/19 to 04/27/2010 (to current)

   NOTE: If Physician is still employed/privileged, end date should indicate "to present" or "to current."

		YES	NO
3.	Did this Physician either leave your employment in good standing, or is currently employed and in good standing? **If no, please attach explanation on a separate sheet.**	☒	☐
	If you answer Yes to questions 4-9, attach an explanation on a separate sheet.		
4.	Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment?	☐	☒
5.	Was this Physician granted a leave of absence while employed by you or at your facility?	☐	☒
6.	Did this Physician have a record of unexcused absences during his/her attendance at this facility or under your employment	☐	☒
7.	Were any restrictions or special requirements placed on this Physician's activities that were not placed on all other employees/staff holding similar positions?	☐	☒
8.	Were any restrictions placed on this Physician's privileges?	☐	☒
9.	Were any formal patient or staff complaints filed against this Physician?	☐	☒

Wisconsin Department of Safety and Professional Services

If you answer Yes to questions 10-15, attach an explanation on a separate sheet.

		YES	NO
10.	Was this Physician denied hospital privileges while employed by you?	☐	☒
11.	Were any incident reports filed involving the professional conduct or behavior of this Physician?	☐	☒
12.	Was this Physician ever subject to non-routine monitoring while at your facility?	☐	☒
13.	Was this Physician involuntarily removed from a call schedule for cause?	☐	☒
14.	Was this Physician subject to non-routine quality assessment review?	☐	☒
15.	Was this Physician the subject of a negative review by a quality assurance or departmental committee?	☐	☒

Name/title of Individual Supplying Information:

Yolanda Jimenez, Office Manager

Signature: [signature]

Date 04/27/20

Hospital/Facility/Employer, please return directly to:

DSPS
Attn: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Or you may fax/email with facility cover sheet/letter to: (608) 251-3036 or DSPSCredMedBD@wisconsin.gov.

Wisconsin Department of Safety and Professional Services

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Madison, WI 53705
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Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

HOSPITAL, FACILITY, AND EMPLOYER VERIFICATION

APPLICANT: **Please forward this form to all hospitals, facilities, and employers where you have had staff privileges, employment, or appointment during the last five (5) years.**

Hospital/Facility/Employer: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name: Luke Wenzel

Name of Hospital/Facility/Employer: University of Nebraska Medical Center

Hospital/Facility/Employer's Address: 983255 Nebraska Medical Center, Omaha, NE 68198-3255

Hospital/Facility/Employer's Daytime Phone: 402-559-6160

Hospital/Facility/Employer, you must answer all of the following questions and provide any additional information in order for this form to be considered complete.

1. What position did this Physician hold at your facility or under your employment?

Resident and Chief Resident

2. What were this Physician's dates of employment or staff privileges at your facility?

07/01/16 to 06/30/20 NOTE: If Physician is still employed/privileged, end date should indicate "to present" or "to current."

		YES	NO
3.	Did this Physician either leave your employment in good standing, or is currently employed and in good standing? **If no, please attach explanation on a separate sheet.**	X	

If you answer Yes to questions 4-9, attach an explanation on a separate sheet.

4.	Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while at your facility or under your employment?		X
5.	Was this Physician granted a leave of absence while employed by you or at your facility?		X
6.	Did this Physician have a record of unexcused absences during his/her attendance at this facility or under your employment		X
7.	Were any restrictions or special requirements placed on this Physician's activities that were not placed on all other employees/staff holding similar positions?		X
8.	Were any restrictions placed on this Physician's privileges?		X
9.	Were any formal patient or staff complaints filed against this Physician?		X

Wisconsin Department of Safety and Professional Services

If you answer Yes to questions 10-15, attach an explanation on a separate sheet.

		YES	NO
10.	Was this Physician denied hospital privileges while employed by you?	☐	☒
11.	Were any incident reports filed involving the professional conduct or behavior of this Physician?	☐	☒
12.	Was this Physician ever subject to non-routine monitoring while at your facility?	☐	☒
13.	Was this Physician involuntarily removed from a call schedule for cause?	☐	☒
14.	Was this Physician subject to non-routine quality assessment review?	☐	☒
15.	Was this Physician the subject of a negative review by a quality assurance or departmental committee?	☐	☒

Name/title of Individual Supplying Information:

Dr. Jennifer Griffin, Residency Program Director

Signature: Jennifer Griffin MD

Date 04/09/20

Hospital/Facility/Employer, please return directly to:

DSPS
Attn: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Or you may fax/email with facility cover sheet/letter to: (608) 251-3036 or DSPSCredMedBD@wisconsin.gov.

Wisconsin Department of Safety and Professional Services

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Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

CERTIFICATE OF POST-GRADUATE TRAINING

(Not necessary if utilizing FCVS)

APPLICANT: **Please forward this form to your post-graduate training program(s) for completion.**

TRAINING PROGRAM: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name:	Luke Wenzel
Hospital/Program Name:	University of Nebraska Medical Center
Hospital/Program Address:	985255 Nebraska Medical Center, Omaha, NE 68198
Hospital/Program's Daytime Phone:	402-559-6160

1. In what type and level(s) of training did this Physician participate at your facility? Indicate below each level of training in which the above named Physician participated in your program. Provide start/end dates, type of training, and whether credit was given for the training.

DATES OF TRAINING(month/day/year)	TYPE OF SPECIALTY TRAINING	FULL CREDIT	PARTIAL CREDIT
PGY 1: 07/01/16 to 06/30/17	OBGYN	Yes ☒ No ☐	Yes ☐ No ☒
PGY 2: 07/01/17 to 06/30/18	OBGYN	Yes ☒ No ☐	Yes ☐ No ☒
PGY 3: 07/01/18 to 06/30/19	OBGYN	Yes ☒ No ☐	Yes ☐ No ☒
PGY 4: 07/01/19 to 06/30/20	OBGYN	Yes ☒ No ☐	Yes ☐ No ☒
Fellowship: __/__/__ to __/__/__		Yes ☐ No ☐	Yes ☐ No ☐
Transitional (Other): __/__/__ to __/__/__		Yes ☐ No ☐	Yes ☐ No ☐

Wisconsin Department of Safety and Professional Services

		YES	NO
2.	Was the internship/residency/fellowship in the United States or Canada accredited by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC)?	☒	☐
3.	Did the Physician either complete the training program in good standing, or is the Physician currently in the training program and in good standing? **If no, please attach explanation on a separate sheet.**	☒	☐
4.	Was this Physician recommended for the Board Certification Examination in this specialty?	☒	☐

If you answer Yes to questions 5-14, attach an explanation on a separate sheet.

5.	Was the Physician asked, or required, to repeat any portion of the training program?	☐	☒
6.	Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while in the program? **If yes, please indicate if this constitutes an adverse formal action.**	☐	☒
7.	Was this Physician granted a leave of absence while in the training program?	☐	☒
8.	Did this individual have a record of unexcused absences during his/her attendance in this training program?	☐	☒
9.	Were any restrictions and/or special requirements placed on this Physician's activities that were not placed on all other residents/fellows at his/her level of training?	☐	☒
10.	Were any formal patient or staff complaints filed against this Physician?	☐	☒
11.	Were any incident reports filed involving the professional behavior or conduct of this Physician?	☐	☒
12.	Was this Physician ever subject to non-routine monitoring while in the training program?	☐	☒
13.	Were any malpractice actions filed naming this Physician as a defendant that involved his/her period of training in the program?	☐	☒
14.	Is there any additional information in this Physician's file that would assist the Board in determining this applicant's eligibility for licensure?	☐	☒

FOR PHYSICIANS CURRENTLY COMPLETING PGY 2 YEAR:

15.	Has the Physician completed and received credit for 12 consecutive months of training program and is expected to continue in the program and complete at least 24 months of post-graduate training?	☐	☐

If yes, please indicate the expected completion date of the 24 months of training: __/__/__

Printed Name of Program Director: Jennifer Griffin

Signature of Program Director: [signature] Date 01/15/20

Post-graduate Training Program, please return directly to:

DSPS
Attn: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Alternatively, you may fax/email with facility cover sheet/letter to: (608) 251-3036 or DSPSCredMedBD@wisconsin.gov.

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
Fax #: (608) 251-3036
Phone #: (608) 266-2112

Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

CERTIFICATE OF POST-GRADUATE TRAINING

(Not necessary if utilizing FCVS)

APPLICANT: **Please forward this form to your post-graduate training program(s) for completion.**

TRAINING PROGRAM: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name:	LUKE RICHARD WENZEL
Hospital/Program Name:	University of Nebraska Medical Center
Hospital/Program Address:	983255 Nebraska Med Center, Omaha, NE 68198-3255
Hospital/Program's Daytime Phone:	402-559-6160

1. In what type and level(s) of training did this Physician participate at your facility? Indicate below each level of training in which the above named Physician participated in your program. Provide start/end dates, type of training, and whether credit was given for the training.

DATES OF TRAINING(month/day/year)	TYPE OF SPECIALTY TRAINING	FULL CREDIT	PARTIAL CREDIT
PGY 1: 07/01/16 to 06/30/17	06 Gyn	Yes ☒ No ☐	Yes ☐ No ☐
PGY 2: 07/01/17 to 06/30/18	06 Gyn	Yes ☒ No ☐	Yes ☐ No ☐
PGY 3: 07/01/18 to 06/30/19	06 Gyn	Yes ☒ No ☐	Yes ☐ No ☐
PGY 4: 07/01/19 to 06/30/20	06 Gyn.	Yes ☒ No ☐	Yes ☐ No ☐
Fellowship: __/__/__ to __/__/__		Yes ☐ No ☐	Yes ☐ No ☐
Transitional (Other): __/__/__ to __/__/__		Yes ☐ No ☐	Yes ☐ No ☐

Wisconsin Department of Safety and Professional Services

		YES	NO
2.	Was the internship/residency/fellowship in the United States or Canada accredited by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC)?	☒	☐
3.	Did the Physician either complete the training program in good standing, or is the Physician currently in the training program and in good standing? **If no, please attach explanation on a separate sheet.**	☒	☐
4.	Was this Physician recommended for the Board Certification Examination in this specialty?	☒	☐
	If you answer Yes to questions 5-14, attach an explanation on a separate sheet.		
5.	Was the Physician asked, or required, to repeat any portion of the training program?	☐	☒
6.	Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while in the program? **If yes, please indicate if this constitutes an adverse formal action.**	☐	☒
7.	Was this Physician granted a leave of absence while in the training program?	☐	☒
8.	Did this individual have a record of unexcused absences during his/her attendance in this training program?	☐	☒
9.	Were any restrictions and/or special requirements placed on this Physician's activities that were not placed on all other residents/fellows at his/her level of training?	☐	☒
10.	Were any formal patient or staff complaints filed against this Physician?	☐	☒
11.	Were any incident reports filed involving the professional behavior or conduct of this Physician?	☐	☒
12.	Was this Physician ever subject to non-routine monitoring while in the training program?	☐	☒
13.	Were any malpractice actions filed naming this Physician as a defendant that involved his/her period of training in the program?	☐	☒
14.	Is there any additional information in this Physician's file that would assist the Board in determining this applicant's eligibility for licensure?	☐	☒
	FOR PHYSICIANS CURRENTLY COMPLETING PGY 2 YEAR:		
15.	Has the Physician completed and received credit for 12 consecutive months of training program and is expected to continue in the program and complete at least 24 months of post-graduate training? n/a.	☐	☐

If yes, please indicate the expected completion date of the 24 months of training: ___/___/___

Printed Name of Program Director: Jennifer Griffin Miller MD MPH

Signature of Program Director: Jennifer Griffin Miller MD Date 04/09/20

Post-graduate Training Program, please return directly to:

DSPS
Attn: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Alternatively, you may fax/email with facility cover sheet/letter to: (608) 251-3036 or DSPSCredMedBD@wisconsin.gov.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Public Health Licensure Unit
Certification of Licensure

This certificate serves as primary source verification of licensure in the State of Nebraska as of the close of the business day before 5/ 4/2020.

Name:	Luke Richard Wenzel DO
Type:	Osteopathic Physician & Surgeon
Number:	2049
Status:	Active
Issued:	06/11/2019
Expiration:	10/01/2020
Education:	05/28/2016 DES MOINES UNIV-OSTEOPATHIC MEDICAL CTR

Disciplinary/Non-Disciplinary Information:

No disciplinary/non-disciplinary actions taken against this license.

If you have questions about this information, please contact the Licensure Unit at (402) 471-2115 or DHHS.LicensureUnit@nebraska.gov.

Current Address

ADDRESS DIVISION: CREDENTIALING
ADDRESS TYPE: MAILING

LUKE WENZEL
[redacted]
LA CROSSE WI 54601
UNITED STATES

Applications

Add New Application

Profession	Application ID	Method	Specialty	Sub Profession	Kind
21 (Medicine and Surgery)	725658	ENDORSEMEN			

Total Applications : 1

Credentials

Credential Number	Granted	Renewal By	Status
73741-21	07/20/2020	10/31/2023	ACTIVE

Total Credentials : 1

Orders (ICE)

No orders found.

Intake Cases (ICE)

No cases found.

Credential: 73741-21 (Medicine and Surgery)
Name: Wenzel, Luke
Granted: 07/20/2020 **Renew By:** 10/31/2023

Renewal: 2021
Status: REGULAR - CURRENT(ACTIVE)
First Fee: 09/22/2021

Online Renewal Log

< Back To Credential

Renewal Year: 2021

Log

Time	Step #	Step Title	Message	
9/22/2021 9:19:59 AM	1	Fee Change	Step completed, advancing to next step in renewal process...	
9/22/2021 9:20:01 AM	2	Name/Address Change Information	Step completed, advancing to next step in renewal process...	
9/22/2021 9:21:09 AM	3	Update Contact Info	Step completed, advancing to next step in renewal process...	
9/22/2021 9:21:15 AM	4	DHS Workforce Study	Step completed, advancing to next step in renewal process...	
9/22/2021 9:21:20 AM	5	Affidavit of Credential Holder	Step completed, advancing to next step in renewal process...	Survey Answers
9/22/2021 9:21:24 AM	6	Legal Status	Step completed, advancing to next step in renewal process...	Survey Answers
9/22/2021 9:21:26 AM	7	Delinquent State Taxes or Delinquent Support	Step completed, advancing to next step in renewal process...	
9/22/2021 9:21:29 AM	8	Conviction Declaration Statement	Step completed, advancing to next step in renewal process...	Survey Answers
9/22/2021 9:21:45 AM	10	Verify Professional Specialties	Step completed, advancing to next step in renewal process...	
9/22/2021 9:21:50 AM	12	Continuing Education Requirement	Step completed, advancing to next step in renewal process...	Survey Answers
9/22/2021 9:21:54 AM	14	List Opt-Out	Step completed, advancing to next step in renewal process...	Survey Answers
9/22/2021 9:22:13 AM	15	Medicine and Surgery Renewal Addendum	Step completed, advancing to next step in renewal process...	Survey Answers
9/22/2021 9:22:52 AM	16	Pay Renewal Fee	Step completed, advancing to next step in renewal process...	

Answers

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 license/credential or for renewal or reinstatement of a license/credential may result in license/credential application processing delays; denial, revocation, suspension or limitation of my license/credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a license/credential renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority may be cause for disciplinary action.

☑ **I have read and I understand the above affidavit of credential holder statement.**

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure as long as my license/credential is current and valid. If information I have provided becomes invalid, incorrect or outdated, since the last renewal or issuance of my license/credential, I understand that I am obliged to provide any information to ensure the information on file for my license/credential remains current, valid, and truthful. I understand that the Department of Safety and Professional Services may view acts of omission as dishonesty and that my duty of disclosure exists as long as my license/credential is current and valid.

☑ **I have read and I understand the above continuing duty of disclosure statement.**

LICENSE/HOLDER CHARGES OR CONVICTIONS

A holder of any of the credentials/licenses set forth in Wis. Stat. s. 440.03(13)(b) who is convicted of a felony or misdemeanor, since the issuance of the license/credential or since the last renewal, in the state or elsewhere shall notify the department in writing of the date, place and nature of the conviction or finding within 48 hours after the entry of the judgment of conviction. Notice shall be made by mail and shall be proven by showing proof of the date of mailing the notice. Notice shall include a copy of the judgment of conviction and a copy of the complaint or other information which describes the nature of the crime and the judgment of conviction in order that the department may determine whether the circumstances of the crime of which the license/credential holder was convicted are substantially related to the practice of the license/credential holder. Form 2252 should be completed and submitted to the department along with the associated fees and all requested documents.

☑ **I have read and understand the above statement regarding the responsibility to report any convictions or misdemeanors, since the issuance or last renewal of my license.**

Answers

If your legal status as a qualified alien or nonimmigrant lawfully present in the United States has changed since the issuance of your credential or your last renewal, please contact the Wisconsin Department of Safety and Professional Services at 608-266-2112 or dsps@wisconsin.gov. I have read and acknowledge this information. ☑

Answers

Since your last renewal *or* initial licensure (if this is your first renewal), do you have any pending charges, prior convictions* and/or have you violated any federal or state laws, or any local ordinances (ordinance violations do not include minor traffic violations that do not involve alcohol or drugs, such as speeding, running stoplights, and seat belt violations)?

*Expunged convictions must be reported.

○ Yes, I have pending charges, prior convictions and/or ordinance violations.

◉ No, I do not have pending charges, prior convictions and/or ordinance violations.

Answers

☑

I have completed 30 hours* of AMA or AOA Category I Continuing Education, including two (2) hours of a Board-approved course related to the Board's Opioid Prescribing Guidelines, pursuant to Wis. Admin. Code ch. Med 13**. I will furnish evidence of completion to the Medical Examining Board upon request.

*Three (3) months of approved post-graduate training is equivalent to 30 hours of Category I credits. Wis. Admin. Code ch. Med 13.04.

Pursuant to Wis. Admin. Code ch. Med 13.02(1q)(b), physicians that do **NOT hold a U.S. Drug Enforcement Administration number to prescribe controlled substances are **NOT** required to complete two (2) hours of a Board-approved course relating to the Board's Opioid Prescribing Guidelines.

Answers

Per Wis. Stat. § 440.14, if you are an individual or a sole proprietor, you may declare that your street address and/or PO Box # not be disclosed on any list of ten or more credential holders that the department furnishes to another person. Please check the box below to make this declaration.

☑ **Please do not disclose my street address and/or PO Box # on lists**

Answers

1. Do you have a medical, physical, or mental condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety that has not been previously disclosed?

If no, you may skip Question 2.

If yes, please submit form #4570 and provide an answer to Question 2..

- ○ Yes
- ◉ No

2. **If yes to Question 1,** are the limitations or impairments caused by your medical, physical, or mental condition reduced or ameliorated because you receive ongoing treatment (with or without medications), you participate in a monitoring program, or are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If yes, provide details along with form #4570.**

- ○ Yes
- ○ No

3. Do you use chemical substance(s), as defined above, that in any way impair or limit your ability to practice medicine with reasonable skill and safety that has not been previously disclosed?

If yes, please submit form #4570.

- ○ Yes
- ◉ No

4. Are you currently (within the last two years) engaged in the illegal use of controlled dangerous substances?

If yes, please submit form #4570.

- ○ Yes
- ◉ No

5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism that has not been previously disclosed?

If yes, please submit form #4570.

○ Yes
◉ No

6. Have you ever been reprimanded, demoted, discipline, cautioned, placed on probation, limited in your practice or privileges, placed on or taken leave greater than 90 days, or terminated by any employer, educational institution, training program, licensing board, hospital, medical facility, professional society, specialty board, or medical body for any reason that has not been previously disclosed?

If yes, please submit form #4570.

○ Yes
◉ No

7. Is disciplinary action pending against you in any jurisdiction that has not been previously disclosed?

If yes, please submit form #4570.

○ Yes
◉ No

8. Has the Drug Enforcement Administration (DEA) withdrawn your DEA number or warned you, or have you been denied a DEA number that has not been previously disclosed?

If yes, please submit form #4570.

○ Yes
◉ No

9. Have there been any medical malpractice claims resulting in payouts made on your behalf that have not been previously disclosed?

If yes, please submit form #4570 as well as form #2829 and supporting documentation, if applicable.

○ Yes
◉ No

Requirements

Add Requirement | Confirm Requirements

Code	Complied	Complied Date	Printed	Comments	Actions
SIG	Met	09/22/2021		status set to Met 09/22/2021 09:21 via online r	
FEE	Met	09/22/2021		added by CRP SR 09/09/2021 15:46	

Name: Wenzel, Luke

Renewal Due: 10/31/2023

Profession: Medicine and Surgery

Credential #: 73741-21

Add History | View Online Activity

History

Date	History Type	History	Actions
02/10/2022	Endorsement Sent	Minnesota Board of Medical Practice	
01/27/2022	Endorsement Sent	Iowa Board of Medicine	
09/24/2021	RenewedAuto	Cred Holder Renewed - Auto Event	
07/20/2020	FromApplicationMethodInformation	Application 725658 by method ENDORSEMEN	
07/20/2020	LicenseGranted	License granted.	
06/30/2020	EndorsedFrom	Endorsed from NBOME	

Renewal Requirements List

Code	Renewal Year	Complied	Complied Date	Printed	Printed Date	Insert Date	Comments
SIG	2021	Met	09/22/2021	No		09/09/2021	status set to Met 09/22/2021 09:21 via online renewal
FEE	2021	Met	09/22/2021	No		09/09/2021	added by CRP SR 09/09/2021 15:46