

Request for Exemption

Ref: Section 655.003, Wis. Stat.
Section Ins 17.28 (4) (c), Wis. Adm. Code



Office of the Commissioner of Insurance
Injured Patients and Families Compensation Fund
P.O. Box 7873
Madison, WI 53707-7873

Instructions: If you are eligible and elect to exempt yourself from the Injured Patients and Families Compensation Fund (Fund), check **ONLY ONE** box below that best indicates the basis for your claimed exemption from mandatory provisions, benefits, and limitations of ch. 655, Wis. Stat. Provide effective date of exempt status, sign, date, and provide contact information as requested.

CHECK ONE TO CLAIM EXEMPTION FROM THE INJURED PATIENTS AND FAMILIES COMPENSATION FUND.

LOCUM TENENS PHYSICIANS SEE LINE 7.

- 1. Effective ___/___/___ (mm/dd/yy), I will not practice in Wisconsin for more than 240 hours during a fiscal year (July 1 through June 30).
- 2. I am employed by the state, a county, or municipality. I will not practice outside that employment for more than 240 hours during a fiscal year (July 1 through June 30). I claim this status effective ___/___/___ (mm/dd/yy).
- 3. I am a federal employee, contractor, or entity covered under the Federal Tort Claims Act (FTCA). I will not practice outside this status for more than 240 hours during a fiscal year (July 1 through June 30) effective ___/___/___ (mm/dd/yy).
- 5. My principal place of practice is not Wisconsin. Effective ___/___/___ (mm/dd/yy), more than 50% of the income from my practice will be derived from outside of Wisconsin or I will render services to more than 50% of my patients outside of Wisconsin during a fiscal year (July 1 through June 30).
- 6. Retired from or discontinued all medical practice in Wisconsin that requires a medical license effective ___/___/___ (mm/dd/yy) .
- 7. I did not practice in Wisconsin effective ___/___/___ (mm/dd/yy) to ___/___/___ (mm/dd/yy) at 12:01 a.m.
NOTE: Newly licensed physicians who have never practiced in the state provide date of licensure: ___/___/___ (mm/dd/yy). Is Wisconsin practice on a locum tenens basis? Yes No
- 8. This corporation/partnership/facility organized and operated in Wisconsin is no longer providing medical services in Wisconsin effective ___/___/___ (mm/dd/yy). If this change is due to merger, please provide name of entity that is now providing services: _____.

I understand that if I claim exemption, I will not have the protection of the Injured Patients and Families Compensation Fund for the exempt period. My status with the Fund will remain as reported above unless or until I, or an insurance carrier on my behalf, notifies the Fund in writing, or through electronic filing, of a change in my status.

Provider Name (please print)	Account No.	License No. or FEIN No.
Provider Signature	Date	Telephone and/or Email Address

Return **EXEMPTION** to: Injured Patients and Families Compensation Fund
Post Office Box 7873
Madison, Wisconsin 53707-7873
Or

Via e-mail to: ociipfcf@wisconsin.gov
Via facsimile to: 608-266-8064
Questions: Call 608-266-6830

A copy of this form is available on the internet at: <http://oci.wi.gov/ipfcf/31-001.pdf>

Submit **PAYMENT** to: State of Wisconsin
Office of the Commissioner of Insurance
Drawer 478
Milwaukee, Wisconsin 53293