Complete forms must be submitted to

info@floridaspodiatricmedicine.gov or mailed to:

Board of Podiatric Medicine

4052 Bald Cypress Way Bin C-08 Tallahassee, FL 32399-3257

1. REPORTING INFORMATION

Board of Podiatric Medicine Podiatric Resident Hospital Program Report Form

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Do not report "Licensed Residents" on this form.



| Annual Period: | From: J | July 1 st _ | YYYY | To: June 3 | 30 th | - | |
|---------------------|------------|------------------------|------|------------|------------------|-------|-----|
| Reporting Hospital: | | | | | | | |
| Program Director: _ | | | | | Telephone: _ | | |
| Email Address: | | | | | | | |
| Program Address: _ | | | | | | | |
| _ | Street and | | | | City | State | ZIP |
| Mailing Address: | | | | | | | |
| <u> </u> | Street and | | | | City | State | ZIP |

2. SUPERVISING PHYSICIANS

List all podiatric physicians on staff or who otherwise serve in a supervisory position. Attach additional sheets if necessary.

| Podiatric Physician Name | License # |
|--------------------------|-----------|
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3. NEW RESIDENTS

List all podiatric residents beginning residency during this reporting period. Do **not** list any podiatric residents who were listed in this section last reporting period. Attach additional sheets if necessary.

| Podiatric Resident Name | Date Residency Begins (MM/DD/YYYY) | Date Residency Ends (MM/DD/YYYY) |
|-------------------------|------------------------------------|-------------------------------------|
| | | |
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| | | |

Each new resident must complete the Podiatric Resident Application for Resident Registration form DH-MQA 1139, a copy of which must be attached to this report.

Florida Board *of* Podiatric Medicine Podiatric Resident Hospital Program Report Form

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4. CONTINUING RESIDENTS

List all podiatric residents continuing in residency. Attach additional sheets if necessary.

| Podiatric Resident Name | Date Residency Began (MM/DD/YYYY) | Date Residency Ends (MM/DD/YYYY) | |
|-------------------------|-----------------------------------|-------------------------------------|--|
| | | | |
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5. RESIDENCY COMPLETION

List all podiatric residents who have completed residency. Attach additional sheets if necessary.

| Podiatric Resident Name | Date Residency Began (MM/DD/YYYY) | Date Residency Ended (MM/DD/YYYY) | |
|-------------------------|--------------------------------------|-----------------------------------|--|
| | | | |
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6. RESIDENCY WITHDRAWN

List all podiatric residents who have withdrawn from the residency program. Attach additional sheets if necessary.

| Podiatric Resident Name | Date Residency Began (MM/DD/YYYY) | n Date Residency Ended (MM/DD/YYYY) | |
|-------------------------|--------------------------------------|--|--|
| | | | |
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| | | | |

Attach a copy of the hospital's most recent residency program evaluation by the Council on Podiatric Medical Education.

| Program Director Signature: | Date: | | |
|-----------------------------|-------|------------|--|
| | | MM/DD/YYYY | |