FLORIDA DEPARTMENT OF HEALTH

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Board of Podiatric Medicine

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Name: _____

Last **First** **Middle**

Social Security Number: _____

APPLICANT HISTORY: (If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)

1. **In the last five years**, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse? [ ] YES [ ] NO

2. **In the last five years**, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? [ ] YES [ ] NO

3. **During the last five years**, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice podiatric medicine? [ ] YES [ ] NO

4. **During the last five years**, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice podiatric medicine? [ ] YES [ ] NO

5. **In the last five years**, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? [ ] YES [ ] NO

6. **During the last five years**, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice podiatric medicine? [ ] YES [ ] NO

Department of Health
Board of Podiatric Medicine
4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257

DH-MQA 1139, 8/2010
64B18-16.006, F.A.C.

FLORIDA DEPARTMENT OF HEALTH

PODIATRIC RESIDENT REGISTRATION

(This form must be completed and attached to the Podiatric Resident Hospital Report then forwarded to the board office within 60 days of commencement of residency)

Name of Resident: _____

Resident's Address: _____

_____

Telephone Number: _____

Email Address: _____

Date of Birth: _____

EQUAL OPPORTUNITY DATA:

Your furnishing of the information below is voluntary. We are required to ask that you furnish this information as part of your voluntary compliance with Section 2-Uniform Guidelines on Employee Selection Procedure 43FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for certification.

Race: _____ White _____ Black _____ Hispanic _____ Asian/Pacific Islander

_____ Native American _____Other (Specify race here)

Sex: _____ Male _____ Female

DPM Degree received from: _____
(An official final transcript must be sent from college directly to Board office)

Date Degree received: _____

Are you licensed to practice Podiatry in any state or foreign country? _____
If yes, each state must complete the attached verification form and submit it directly to the Board office.

Program Information

Name of Hospital: _____

Program Director's Name: _____

Telephone Number: _____ Email Address: _____

Mailing Address: _____

_____

Date Residency Starts: _____
Month/Day/Year

Date Residency Ends: _____
Month/Day/Year

Applicant Name: _____

1. **GENERAL HISTORY:** [Attach additional sheet(s) if necessary]

   a. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction, or have you ever been a defendant in a military court-martial? Do not include parking or speeding violations. Yes _____ No _____

   If yes, please list date, jurisdiction (state and county), offense, disposition and all relevant information:

   _____

   _____

   b. Have you ever been the subject of any disciplinary action by the licensing authority of any state or are you the subject of any pending investigation or disciplinary action? Yes _____ No _____

   If yes, provide details: _____

   _____

2. **Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.**

   a. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? Yes _____ No _____ If no, do not answer (b)

   b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? Yes _____ No _____

   c. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? Yes _____ No _____ If no, do not answer (e)

   d. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes _____ No _____

   e. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? Yes _____ No _____ If no, do not answer (f) or (g)

   f. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? Yes _____ No _____

   g. Did the termination occur at least 20 years prior to the date of this application? Yes _____ No _____

As a reminder to all applicants, please understand that Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

I, _____, certify the above information is true and correct.
Print Name

_____
Signature of Registrant

LICENSE VERIFICATION

INSTRUCTIONS TO THE APPLICANT:
1. Complete the information in Part I only.
2. This form must be returned by the Board or agency which issued your license.

PART I: TO BE COMPLETED BY APPLICANT

Name:_____ DOB:__/__/_____
Address:_____
Title of License:_____License No.:_____

PART II: TO BE COMPLETED BY THE STATE BOARD OFFICE

The individual listed above has entered into a residency program in Florida. Before further consideration, we require the information requested on this form. The Board may submit their standard verification form in lieu of completing this form, as long as you indicate whether or not discipline has been taken against the license, and affix the Board seal.

Name:_____
Title of License:_____
Original Issue Date:_____
License Number:_____

THIS LICENSE IS CURRENTLY:
[ ] Active [ ] Inactive [ ] Temporary [ ] Other (Explain)

THIS LICENSE WAS OBTAINED BY:
[ ] Examination [ ] Grandfathering [ ] Reciprocity/Endorsement

ACTION TAKEN AGAINST LICENSE:
[ ] No Disciplinary Action Taken [ ] Disciplinary Action Taken*
(*If disciplinary action was taken, please provide documentation)

Signature:_____ Title:_____

Date:_____State Board:_____Please Affix Board Seal

* If disciplinary action has been taken against this licensee, please provide our office with any documentation regarding the disciplinary action.