



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:(optional) _____

Florida law provides that email addresses are public record. Do not provide an email address if you do not want it released pursuant to a public records request.

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: _____

Florida law provides that email addresses are public record. Do not provide an email address if you do not want it released pursuant to a public records request.

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: _____

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes.. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? Yes _____ No _____ ? **(If you responded NO, skip to 3)**
- a. If "yes" to 2, for felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation? Yes _____ No _____
- b. If "yes" to 2, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes). Yes _____ No _____
- c. If "yes" to 2, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? es _____ No _____
- d. If "yes" to 2, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? Yes _____ No _____
(If "yes", please provide supporting documentation)
3. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes _____ No _____
- a. If "yes" to 6, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? Yes _____ No _____
4. 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 4a.)**

NAME: _____

- a. 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 _____
- 5. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes _____ No _____ (If "No", do not answer 5a or 5b.)
 - a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes _____ No _____
 - b. Did the termination occur at least 20 years before to the date of this application? Yes _____ No _____
- 6. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? 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.

