



**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:

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- 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: \_\_\_\_\_

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**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 (d)
- 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.

