STATE OF CALIFORNIA
BOARD OF
PODIATRIC
MEDICINE

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

APPLICATION FOR DUPLICATE LICENSE / CERTIFICATE

FOR BPM USE ONLY			
Fee paid:		Receipt #:	
Date Cashiered:		Cashier's Initials:	
Date Approved:		Date Denial:	
Approved Initial:			

To request a duplicate license of a Doctor of Podiatric Medicine permanent license or a Doctor of Podiatric Medicine resident license, you must complete this form and return it to the mailing address below along with a $40 check or money order made payable to: *Board of Podiatric Medicine*. Please provide all information requested below.

Please print or type. Illegible applications will be returned.

LICENSEE INFORMATION:

LICENSE NUMBER:	E-MAIL/PHONE NUMBER:
DATE OF BIRTH:	EXPIRATION DATE:
NAME:	

The address of record is public information and will be displayed on the Board of Podiatric Medicine's website.

STREET ADDRESS

CITY STATE ZIP CODE COUNTRY

Please provide the following information:

Request for Duplicate:	☐ Wall Certificate	☐ Wallet (pocket) license
License Type:	☐ Permanent license	☐ Resident license
Check all that apply:	☐ Lost	☐ Stolen
	☐ Mutilated	☐ Destroyed
	☐ Name Change	☐ Address Change

Provide an explanation of the circumstances of the loss:

PHOTOGRAPH:

Photograph

Affix a 3" x 5" Photo Here

Photo Must Be Recent and Must Be of your Head and Shoulder Areas Only

Altered Photographs are NOT acceptable

I hereby declare under penalty of perjury under the laws of the state of California, that the photo of myself attached hereto, was taken on or about _____.

My age then being _____ years.

Hair color _____

Eye Color _____

Height _____

Weight _____

Identifying marks _____

_____

Upon receipt of this application and the fees, a request for a duplicate license will be submitted. This is a controlled document and is not printed in our office, rather through another state agency. You should receive your certificate in the mail within 2-3 weeks.

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA TO THE TRUTH AND ACCURACY OF THE ABOVE INFORMATION.

Name (Please print) _____ License Number _____

Signature _____ Date _____

Signature and date are required to process this request.

All items in this application are mandatory; none are voluntary. This information is requested by the Licensing Program of the California Board of Podiatric Medicine. Failure to provide any of the requested information may result in this application being rejected as incomplete. The information provided will be used to determine your eligibility for waiver of the Continuing Medical Education or Continuing Competence requirements pursuant to Section 1339.678 of Title 16, California Code of Regulations. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act contacting the custodian of records at 2005 Evergreen Street, Suite 1300, Sacramento, CA 95815.

This form must be mailed to the board at 2005 Evergreen St., Ste. 1300, Sacramento, CA 95815