STATE OF CALIFORNIA
BOARD OF
PODIATRIC
MEDICINE

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

LICENSE INFORMATION FOR A CERTIFICATE TO PRACTICE PODIATRIC MEDICINE

MINIMUM REQUIREMENTS TO APPLY FOR A LICENSE

- To be eligible for licensure in the state of California as a Doctor of Podiatric Medicine, applicants must have graduated from an approved college or school of podiatric medicine approved by the California Board of Podiatric Medicine (BPM).

- Section 31(e) of the Business and Professions Code allows the State Board of Equalization and the Franchise Tax Board to share taxpayer information with the Board. A license issued by the Board may be suspended if state tax obligation is not paid. Disclosure of your United States Social Security Number or Individual Taxpayer Identification Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405 (c)(2)(c)) authorize collection of your social security number. *Reporting a number on your Application that is not your U.S. Social Security Number of Individual Taxpayer Identification Number may be grounds for denial of licensure.*

GENERAL INFORMATION

- As an applicant, you personally are responsible for all information disclosed on your Application, Forms P1A – P1F, including any responses that may have been completed on your behalf by others. An application may be denied based upon omissions, falsification or misrepresentation of any item or response on the application or any attachment. The California Board of Podiatric Medicine considers violations of an ethical nature to be a serious breach of professional conduct.

- *Processing Times:* Application materials are processed in the date order in which the application is received in our office. All application forms and supporting materials are stamped with the date and time received. Generally, you should anticipate receiving written correspondence confirming status of the application for licensure within 15 days of submission of the application.

- *Fingerprints:* Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. You will need to use the *Request for Live Scan Service* form included in this Application packet or on our website. Please refer to the following website for a listing of Live Scan facilities in California: http://ag.ca.gov/fingerprints/publications/contact.php.

  Applicants residing outside California must submit two completed fingerprint cards or have your fingerprints completed at a California Live Scan facility. If fingerprint cards are needed, please call our office at (916) 263-2647 and they will be mailed to you. All personal data must be completed on the fingerprint cards.

If you have ever been convicted of a misdemeanor or felony, the record of the conviction will be reported to the Board as a result of your fingerprint inquiry. *Criminal Records Check from both the California Department of Justice and the Federal Bureau of Investigation must be received prior to the issuance of a Doctor of Podiatric Medicine License.*

- *Convictions:* Note that convictions that were adjudicated in juvenile courts or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e) or section 11360(b) which are two years or older should not be reported. Convictions expunged or set aside pursuant to section 1203.4, 1203.4a or 1203.41 of the California Penal code or equivalent non-California law MUST be disclosed. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application. The Board receives information regarding convictions that have been expunged.

- *Grounds for Denial:* Each applicant's credential for podiatric licensure in California are reviewed on an individual basis. The Board has the authority to deny licensure based upon an applicant's act of dishonesty, unprofessional conduct, conviction of a crime, discipline of another state license, or inability to practice medicine safely.

APPLICATION INFORMATION

Listed below are the application and supporting material requirements for licensure as a California Doctor of Podiatric Medicine. This list is not all-inclusive as additional information may be necessary based on responses provided on your Application or information obtained from other entities. Please refer to the *License Application Checklist* and our website for further detailed information regarding each requirement.

☒	Application for Doctor of Podiatric Medicine (Form P1A-P1F) Complete, certify and submit with a photograph.
☒	Background clearance Copy of Live Scan Request form (CA resident) **or** Two Fingerprint Cards (outside CA).
☒	Application fees of $69 This includes fees for application processing and background clearance. Please make check or money orders payable to the *CA Board of Podiatric Medicine*. Unfortunately, at this time we are unable to accept credit card transactions.
☒	Official Pre-professional Postsecondary Education transcripts (from all colleges or universities attended) (Form P2) An original official school transcript, prepared on university letterhead affixed with the signature of the dean or registrar and the school seal is required. A transcript is required from each school of attendance. ***Transcript(s) must be mailed directly from the school to the Board to be acceptable.***
☒	Official Podiatric Medical Education transcripts (Form P2) An original official medical school transcript, prepared on university letterhead affixed with the signature of the dean or registrar and the medical school seal, documenting all of the basic science and clinical courses completed during the medical curriculum is required. A transcript is required from each school of attendance. ***Transcript(s) must be mailed directly from the school to the Board to be acceptable.***

☒	License Verification/Letter of Good Standing by State Licensing Agency (if applicable) (Form P3) Forward this form to licensing agencies by any state or country in which you have held a medical license, including temporary or limited/resident licenses. ***Verification must be completed and mailed directly from the licensing agency to the Board to be acceptable.***
☒	Certificate of Approved Residency Training (Form P4A – P4B) Forward this form to your Residency Director for completion and return directly to the Board. In lieu of this form, your Residency Director may prepare a letter on official letterhead with original signature, verifying completion of the program. ***Certification must be completed by each residency program and mailed directly from the residency program to the Board to be acceptable.***
☒	Official American Podiatric Medical Licensing Examination (APMLE) Parts I, II & III (PMLexis) Scores (Forms P5 & P6) Parts I & II – resident license; Parts I, II & III for permanent license ***Each score report must be an original, official score report mailed directly from FPMB to the Board to be acceptable.***
☒	Memorandum of Understanding for Approved Residency Program Participation **or** Memorandum of Understanding for "Candidate Status" Residency Program Participation (Form 7A or P7B) Complete and send in with your application acknowledging your participation a residency program.
☒	Disciplinary Databank Report Request this report directly from the Federation of Podiatric Medical Boards (FPMB) website at www.fpmb.org. ***This report must be mailed directly from FPMB to the Board to be acceptable.***
☒	Explanation to Question # ____ (if applicable) The *Explanation to Questions* # ____ form may be used to provide a detailed written explanation for a "yes" response to a question on the application. The Board will also accept a signed and dated letter of explanation.
☒	Birth Month Licensure Request Complete the *Birth Month Request* form and submit it with your application.
☒	License fees: Resident/Limited License fee $60 Permanent License $900 This fee is payable upon meeting all licensure requirements or at any point during the application process. Please make check or money orders payable to the *CA Board of Podiatric Medicine*. Unfortunately, at this time we are unable to accept credit card transactions.

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LICENSE APPLICATION CHECKLIST FOR A CERTIFICATE TO PRACTICE PODIATRIC MEDICINE

(Do Not Submit – Keep for your records)

Application, Fees and Fingerprints			
☐	Application Fee	A minimum of $69 is required to submit an application for licensure. This includes fees for application processing and background clearance. Please make check or money orders payable to the *CA Board of Podiatric Medicine*. Unfortunately, at this time we are unable to accept credit card transactions.	Notes/Date Sent:
☐	Application (P1A-P1F) ☐ P1A ☐ P1B ☐ P1C ☐ P1D ☐ P1E ☐ P1F	Complete all fields and answer all questions.	Notes/Date Sent:
☐	Fingerprints: Live Scan Request Form OR Two Fingerprint Cards	Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. A copy of the *Request for Live Scan* form must be submitted with your application. Applicants residing outside California may submit two completed fingerprint cares or visit a California Live Scan facility. If fingerprint cards are needed, please call our office at (916) 263-2647 and they will be mailed to you. <u>All personal data must be completed on the fingerprint cards</u>.	Notes/Date Sent:
☐	Official Pre-professional Postsecondary Education transcripts (Form P2)	All official school transcript(s) required from each college or university attended. ***Transcript(s) must be mailed directly from the school to the Board to be acceptable.***	Notes/Date Sent:
☐	Official Podiatric Medical School (Form P2)	An official podiatric medical school transcript is required from each podiatric medical school attended. ***Transcript(s) must be mailed directly from the school to the Board to be acceptable.***	Notes/Date Sent:
☐	License Verification/Letter of Good Standing by State Licensing Agency (if applicable) (Form P3)	This form is to be completed by each licensing agency by any state or country in which you have held a medical license, including temporary or limited/resident licenses. ***Verification must be completed and mailed directly from the licensing agency to the Board to be acceptable.***	Notes/Date Sent:

☐	Certificate of Approved Residency Program Training (Form P4)	Forward this form to your Residency Director for completion and return directly to the Board. In lieu of this form, your Residency Director may prepare a letter on official letterhead with original signature, verifying completion of the program. ***Certification must be completed and mailed directly from the residency program to be the Board to be acceptable.***	Notes/Date Sent:
☐	Official American Podiatric Medical Licensing Examination (APMLE) and Part III (PMLexis) reports: ☐ Parts I & II (Form P5) ☐ Part III (Form 6) **(Permanent License Only)**	Official board score reports may be requested from the following websites: NPBME: www.ample.com FPMB: www.fpmb.org ***Each score report must be an original, official score report mailed directly from the FPMB to the Board to be acceptable.***	Notes/Date Sent:
☐	Memorandum of Understanding (MOU) for: ☐ Approved Residency Program Participation (Form P7A) ☐ "Candidate Status" Residency Program Participation (Form P7B)	Complete all fields, sign and date. MOU for Approved Residency Program Participation means that your residency program has been approved by the Council on Podiatric Medical Education (CPME). MOU for "Candidate Status" Residency Program Participation means that your residency program has **not** been approved by the CPME. View the List of Approved Residencies on visit CPME's website to determine eligibility: www.cpme.org.	Notes/Date Sent:
☐	Disciplinary Databank Report **(Permanent License Only)**	Request this report directly from the Federation of Podiatric Medical Boards (FPMB) website at www.fpmb.org. ***This report must be mailed directly from the FPMB to the Board to be acceptable.***	Notes/Date Sent:
☐	Explanation to Question # ____ (if applicable)	The *Explanation to Questions* # ____ form may be used to provide a detailed written explanation for a "yes" response to a question on the application. The Board will also accept a signed and dated letter of explanation.	Notes/Date Sent:
☐	License Expiration Advisory and Request for Birth Month Licensure	Complete the *License Expiration Advisory and Request for Birth Month* form and submit it with your application.	Notes/Date Sent:
☐	License fees: ☐ Resident License $60 ☐ Permanent License $900	A license fee of is payable upon meeting all licensure requirements or at any point during the application process. Please make check or money orders payable to the *CA Board of Podiatric Medicine*. Unfortunately, at this time we are unable to accept credit card transactions.	Notes/Date Sent:

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LIVE SCAN INFORMATION

CALIFORNIA DOES NOT HAVE LIVE SCAN LINKS TO ANY OTHER STATES.

The *Request for Live Scan* form is required to have your fingerprints processed by Live Scan. This form must be completed in triplicate; therefore, THREE copies will be printed automatically when printing this form. Please ensure that all personal data is provided on *each of the three forms.* The last section of the form requires information form the fingerprint agency; please ensure this information is completed or the forms will be void. **It is the responsibility of the applicant to ensure that the person scanning the fingerprints submits TWO digital prints, one for the DOJ and one for the FBI.**

Applicants can access the website, http://ag.ca.gov/fingerprints/publications/contact.htm to obtain the names and location of approved fingerprint sites. After completing the Live Scan process, applicants must submit ONE of the three forms with the initial application to document the scanning of their fingerprints. The results of Live Scan fingerprints are generally received within five (5) days. The results of paper fingerprint cards are generally received within twelve (12) weeks.

Whether you use Live Scan or paper fingerprint cards, you will be charged an administrative fee by the local agency that scans the prints or provides the inked impression. This is in addition to the fingerprint processing fee that must be paid to the California Board of Podiatric Medicine with your application. For information about the fingerprint clearance process and time frames, you may access http://ag.ca.gov/consumers/morefqs.php.

Because applicants from medical profession must be concerned with sanitary issues, they wash and scrub their hands so much that images of their fingerprints are often difficult to read. When the impressions are of such poor quality that they cannot be searched in DOJ's or FBI's fingerprint data base, the fingerprints (whether Live Scan or paper cards) are rejected and reprints will be necessary. Therefore, please advise the person processing your fingerprints that extra care needs to be given to ensure that clear impressions have been made.

FINGERPRINT CLEARANCES FROM BOTH THE DOJ AND THE FBI MUST BE RECEIVED PRIOR TO THE ISSUANCE OF A DOCTOR OF PODIATRIC MEDICINE LICENSE IN CALIFORNIA

If you have ever been convicted of a misdemeanor or felony, the record of conviction will be reported to the Board as a result of your fingerprint inquiry.

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission

ORI: AO434 (Code assigned by DOJ) Type of Application: License, Certification, Permit

Job Title or Type of License, Certification or Permit: Doctor of Podiatric Medicine

Agency Address Set Contributing Agency:

Board of Podiatric Medicine — Agency authorized to receive criminal history information
03802 — Mail Code (five digit code assigned by DOJ)

2005 Evergreen Street, Suite 1300 — Street No. Street or P.O. Box
Kia-Maria Zamora — Contact Name (Mandatory for all school submissions)

Sacramento — City
CA — State
95815 — Zip Code
(916) 263-2649 — Contact Telephone No.

Name of Applicant: (please print) Last First MI

Alias: Last First

Driver's License No.

Date of Birth: Sex: ☐ Male ☐ Female

Misc. No. BIL- BIL - 100026 (Agency Billing Number (if applicable))

Height: Weight: Misc. No:

Eye Color: Hair Color: Home Address: N/A (Street or P.O. Box)

Place of Birth: N/A (City, State and Zip Code)

SOC#

Your Number: BPM A0434 (OCA No. (Agency Identifying No.))

Level of Service ☒ DOJ ☒ FBI

If resubmission, list Original ATI No.

Employer: (Additional response for agencies specified by statute)

N/A — Employer Name

N/A — Street No. Street or P.O. Box
N/A — Mail Code (five digit code assigned by DOJ)

N/A — City State Zip Code
( ) N/A — Agency Telephone No. (optional)

Live Scan Transaction Completed By: Name of Operator Date:

Transmitting Agency ATI No. Amount Collected/Billed

BCII 8016 (Rev 9/02) ORIGINAL – Live Scan Operator, SECOND COPY – Requesting Agency, THIRD COPY - Applicant

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission

ORI: A0434 (Code assigned by DOJ) Type of Application: License, Certification, Permit

Job Title or Type of License, Certification or Permit: Doctor of Podiatric Medicine

Agency Address Set Contributing Agency:

Board of Podiatric Medicine — Agency authorized to receive criminal history information
03802 — Mail Code (five digit code assigned by DOJ)

2005 Evergreen Street, Suite 1300 — Street No. Street or P.O. Box
Kia-Maria Zamora — Contact Name (Mandatory for all school submissions)

Sacramento — City
CA — State
95815 — Zip Code
(916) 263-2649 — Contact Telephone No.

Name of Applicant: (please print) Last First MI

Alias: Last First

Driver's License No.

Date of Birth: Sex: ☐ Male ☐ Female

Misc. No. BIL- BIL - 100026 (Agency Billing Number (if applicable))

Height: Weight: Misc. No:

Eye Color: Hair Color: Home Address: N/A (Street or P.O. Box)

Place of Birth: N/A (City, State and Zip Code)

SOC#

Your Number: BPM A0434 (OCA No. (Agency Identifying No.)) Level of Service ☒ DOJ ☒ FBI

If resubmission, list Original ATI No.

Employer: (Additional response for agencies specified by statute)

N/A — Employer Name

N/A — Street No. Street or P.O. Box
N/A — Mail Code (five digit code assigned by DOJ)

N/A — City State Zip Code
( ) N/A — Agency Telephone No. (optional)

Live Scan Transaction Completed By: Name of Operator Date:

Transmitting Agency ATI No. Amount Collected/Billed

BCII 8016 (Rev 9/02) ORIGINAL – Live Scan Operator, SECOND COPY – Requesting Agency, THIRD COPY - Applicant

REQUEST FOR LIVE SCAN SERVICE
Applicant Submission

ORI: A0434 (Code assigned by DOJ) Type of Application: License, Certification, Permit

Job Title or Type of License, Certification or Permit: Doctor of Podiatric Medicine

Agency Address Set Contributing Agency:

Board of Podiatric Medicine — Agency authorized to receive criminal history information
03802 — Mail Code (five digit code assigned by DOJ)

2005 Evergreen Street, Suite 1300 — Street No. Street or P.O. Box
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CA — State
95815 — Zip Code
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Name of Applicant: (please print) Last First MI

Alias: Last First

Driver's License No.

Date of Birth: Sex: ☐ Male ☐ Female

Misc. No. BIL- BIL - 100026 (Agency Billing Number (if applicable))

Height: Weight: Misc. No:

Eye Color: Hair Color: Home Address: N/A (Street or P.O. Box)

Place of Birth: N/A (City, State and Zip Code)

SOC#

Your Number: BPM A0434 (OCA No. (Agency Identifying No.))

Level of Service ☒ DOJ ☒ FBI

If resubmission, list Original ATI No.

Employer: (Additional response for agencies specified by statute)

N/A — Employer Name

N/A — Street No. Street or P.O. Box
N/A — Mail Code (five digit code assigned by DOJ)

N/A — City State Zip Code
( ) N/A — Agency Telephone No. (optional)

Live Scan Transaction Completed By: Name of Operator Date:

Transmitting Agency ATI No. Amount Collected/Billed

BCII 8016 (Rev 9/02) ORIGINAL – Live Scan Operator, SECOND COPY – Requesting Agency, THIRD COPY - Applicant

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LICENSE EXPIRATION ADVISORY AND REQUEST FOR BIRTH MONTH LICENSURE

California licensing regulations specify that a license expires at 12 midnight on the last day of the birth month of the licensee during the second year of a two year term. If you are licensed in your birth month, your initial license will be valid for a full 24-month term. If you are licensed in a month other than your birth month, the term of your *initial license* will be less than 24-months.

Please indicate your preference by checking one of the options listed below:

☐	I would like to wait until my birth month of _____ to be licensed.
☐	I would like to be licensed as soon as my application is processed and approved. I understand and acknowledge my *initial license* will be valid for less than a 24-month term.

Printed Name of Applicant: _____

Date of Birth: _____

Signature of Applicant: _____

Date: _____

Please return the form using one of the following methods:

1. Submit the completed form with your initial application.
2. Fax the completed form to the Board at (916) 263.2651.
3. Mail the completed form to the Board at the address listed below.

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EXPLANATION TO APPLICATION QUESTION # _____

This form may be used to provide a detailed written explanation for a "yes" response to a question on the Application. Please use as many forms as necessary to provide a detailed explanation. A separate form is to be used for each question.

Please print or type. Illegible applications will be returned.

APPLICANT'S INFORMATION

NAME:

Date of Birth:	**SSN or ITIN:**	**Podiatric Medical School of Graduation:**

NARRATIVE EXPLANATION

SIGNATURE: **DATE:**

Applicant's signature and date are required.

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LICENSE APPLICATION FOR A CERTIFICATE TO PRACTICE PODIATRIC MEDICINE

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

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions.

Please print or type. Illegible applications will be returned.

☐ **Limited / Resident License** ☐ **Permanent License**

PERSONAL INFORMATION

BPM Use Only

Name:

Other Name/Alias:

Social Security Number/Individual Taxpayer Identification Number: Gender: ☐ Male ☐ Female

Date of Birth: Place of Birth:

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

Address:

City / State / Zip:

Telephone Number: Home Work Cell

E-mail Address: ☐

1. Have you ever filed an application for licensure in California that has been withdrawn, abandoned, or denied? *If YES, give date of previous application:*	☐ Yes	☐ No	☐
2. Have you previously held a Doctor of Podiatric Medicine license in California? *If YES, give date and license number:*	☐ Yes	☐ No	☐
3. a. Have you served or are you currently serving in the military?	☐ Yes	☐ No	☐
b. Are you married, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders? *If YES, please provide evidence of your legal union and your spouse or partner's military duty orders.*	☐ Yes	☐ No	☐
c. Are you requesting expediting of this application under AB 1904 (Block, 2012) for spouses of the military? *If YES, please provide evidence of your legal union, your spouse or partner's military duty orders and current licensure in another state, district or territory of the US in the profession for which you are seeking licensure.*	☐ Yes	☐ No	☐
d. Are you requesting to expedite this application for an honorably discharged former active duty member of the Armed Forces of the United States? *If YES, please provide evidence of the honorably discharged military orders.*	☐ Yes	☐ No	☐

P1A

PREMEDICAL EDUCATION

BPM Use Only

4. List Name and address of all colleges or universities where premedical education was received.

Name of Premedical School(s)	Mailing Address	Attendance Dates		BPM Use Only
		Start		☐
		End		
		Start		☐
		End		
		Start		☐
		End		
		Start		☐
		End		

PODIATRIC MEDICAL EDUCATION

5. List Name and address of all colleges or universities where Podiatric Medical education was received.

Name of Podiatric School(s)	Mailing Address	Attendance Dates		BPM Use Only
		Start		☐
		End		
		Start		☐
		End		
School of Graduation	Title of Degree Awarded	Issue Date of Degree		
				☐

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

			BPM Use Only
6. Did you ever take a leave of absence during medical school?	☐ Yes	☐ No	☐
7. Were you ever placed on probation?	☐ Yes	☐ No	☐
8. Were you ever disciplined or placed under investigation?	☐ Yes	☐ No	☐
9. Were any negative reports ever filed by your instructor?	☐ Yes	☐ No	☐
10. Were any limitations or special requirements imposed on you because of questions of academic or disciplinary problems, or for any other reason?	☐ Yes	☐ No	☐

A "yes" response to questions 15 – 19 requires a signed and dated written explanation.

EXAMINATIONS

			BPM Use Only
11. Have you ever been found to have engaged in irregular behavior during an examination?	☐ Yes	☐ No	☐
12. Have you ever been subject to an investigation by an examination entity?	☐ Yes	☐ No	☐

A "yes" response to questions 20 – 21 requires a signed and dated written explanation.

13. List all of the examinations you have taken administered by the National Board of Podiatric Medical Examiners.

Examination	Location	Date	Result	BPM Use Only
APMLE Part I				☐
APMLE Part II				☐
Part III (PMLexis)				☐

POSTGRADUATE TRAINING

BPM Use Only

14. Have you completed, or are you currently participating in a residency program approved by the Council on Podiatric Medical Education? ☐ Yes ☐ No ☐
*If YES, list name and address of the program facility. Submit an original **Certificate of Approved Residency Program Training (Form P4A-P4B).** Please use additional sheet of paper if necessary.*

Name of Residency Program and Residency Type	Mailing Address	Attendance Dates	
		Start	
		End	

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING

15. Have you ever received partial or no credit for a postgraduate training program?	☐ Yes	☐ No	☐
16. Have you ever taken a leave of absence or break from your training?	☐ Yes	☐ No	☐
17. Have you ever been terminated, dismissed or expelled from a program?	☐ Yes	☐ No	☐
18. Have you ever resigned from a program?	☐ Yes	☐ No	☐
19. Were you ever placed on probation for any reason?	☐ Yes	☐ No	☐
20. Were you ever disciplined or placed under investigation?	☐ Yes	☐ No	☐
21. Were any incident reports ever filed by instructors?	☐ Yes	☐ No	☐
22. Were any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐ Yes	☐ No	☐
23. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	☐ Yes	☐ No	☐

A "yes" response to questions 15 – 23 requires a signed and dated written explanation.

PODIATRIC MEDICAL LICENSE

24. Have you ever held, or do you currently hold a podiatric medicine license in any other U.S. state or U. S. territory or Canadian province or foreign country? ☐ Yes ☐ No ☐
*If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each license. Submit a **Request for License Verification/Letter of Good Standing by State Licensing Agency (Form P3**) for a license verification for <u>each</u> state in which you are licensed or have been licensed. Please use additional sheet of paper if necessary.*

State or Country	License Number	Date of Issuance	Dates of Practice	
			Start	
			End	☐
			Start	
			End	☐
			Start	
			End	☐

MALPRACTICE HISTORY

25. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement?	☐ Yes	☐ No	☐
26. Has a judgment or arbitration ever been awarded in the amount of $30,000 or more?	☐ Yes	☐ No	☐

A "yes" response to questions 25 – 26 requires a signed and dated written explanation.

DISCIPLINARY HISTORY			BPM Use Only
These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Government Agency of any U.S. state or territory, Canadian province, or foreign country.			
27. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	☐ Yes	☐ No	☐
28. Have you ever been denied a license to practice podiatric medicine?	☐ Yes	☐ No	☐
29. Is any denial pending against you?	☐ Yes	☐ No	☐
30. Have you ever had any license to practice podiatric medicine subjected to any disciplinary action?	☐ Yes	☐ No	☐
31. Is any disciplinary action pending against any of your licenses to practice podiatric medicine?	☐ Yes	☐ No	☐
32. Have you ever surrendered a license to practice podiatric medicine?	☐ Yes	☐ No	☐
33. Have you ever had any license to practice podiatric medicine revoked, suspended, or placed on probation?	☐ Yes	☐ No	☐
34. Have you ever had any license to practice podiatric medicine subjected to any action including, *but not limited to*, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	☐ Yes	☐ No	☐
35. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?	☐ Yes	☐ No	☐
36. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	☐ Yes	☐ No	☐
37. Is any disciplinary action pending against your hospital or staff privileges?	☐ Yes	☐ No	☐
38. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	☐ Yes	☐ No	☐
39. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?	☐ Yes	☐ No	☐
A "YES" response to questions 27 – 39 requires a signed and dated written explanation. Include certified copies of all applicable court records and/or other legal documents, including all statements of disposition, relief from disabilities, certification of conduct or other documents.			
CRIMINAL RECORD HISTORY			
Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application. **For each conviction disclosed to questions 40 – 43, you must submit certified copies of the arresting agency report, certified copies of the court documents, including a plea form and court docket, and a signed and dated descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e. dates and location of the incident and all circumstances surround the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.**			
40. Have you ever been convicted of, or pled guilty or nolo contendere to **ANY** offense in the United States, its territories, or a foreign country? **This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e) or section 11360(b) which are two years or older should NOT be reported. Convictions that were later dismissed pursuant to sections 1203.4, 1203.4a, or 1203.41 of the California Penal Code or equivalent non-California law MUST be disclosed.**	☐ Yes	☐ No	☐
41. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?	☐ Yes	☐ No	☐

CRIMINAL RECORD HISTORY continued			BPM Use Only
42. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?	☐ Yes	☐ No	☐
43. Are you a registered sex offender?	☐ Yes	☐ No	☐
PRACTICE IMPAIRMENT OR LIMITATIONS			
If you give an affirmative answer to any of the questions below, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are eligible for licensure.			
44. Have you ever enrolled in, been required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	☐ Yes	☐ No	☐
45. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	☐ Yes	☐ No	☐
46. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice podiatric medicine safely?	☐ Yes	☐ No	☐
47. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice podiatric medicine safely?	☐ Yes	☐ No	☐
48. Do you have any other condition that may in any way impair or limit your ability to practice podiatric medicine safely?	☐ Yes	☐ No	☐
49. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice podiatric medicine safely?	☐ Yes	☐ No	☐
A "yes" response to questions 44 – 49 requires a signed and dated written explanation.			

Applicants who answer "NO" to the questions on this application, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application.
If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.

For each conviction disclosed, remember you must submit certified copies of the arresting agency report, certified copies of the court documents, including a plea form and court docket, and a signed and dated descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e. dates and location of the incident and all circumstances surround the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.

As a reminder, if an affirmative answer is given to any of the questions on this application, the Board will make an individual assessment of the nature, the severity and the duration of the situation and circumstances.

FINGERPRINT CLEARANCES FROM BOTH THE DEPARTMENT OF JUSTICE AND THE FEDERAL BUREAU OF INVESTIGATIONS MUST BE RECEIVED PRIOR TO THE ISSUANCE OF A DOCTOR OF PODIATRIC MEDICINE LICENSE IN CALIFORNIA

If you have ever been convicted of a misdemeanor or felony, the record of conviction will be reported to the Board as a result of your fingerprint inquiry.

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 _____

_____

NOTICE: *All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the delay of processing your application or being rejected as being incomplete. The information provided will be used to determine qualifications for licensure per section 2479 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other podiatric or medical licensing authority or the Federation of the Podiatric Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Executive Officer of the Board of Podiatric Medicine is the custodian of records.*

APPLICANT DECLARATION

I, _____, certify that I am the person referred to in this foregoing application for a certificate to practice Podiatric Medicine in the State of California and that I have carefully read and thoroughly understand all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

I request that the Board of Podiatric Medicine initiate a review of the records to determine my eligibility for licensure in California. In making this request, I authorize the release of any information or records held by any individual or agency, relative to my training and qualifications as a Doctor of Podiatric Medicine upon request by the Board for the use in evaluating my application.

I am the lawful holder of the degree of Doctor of Podiatric Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof.

I understand that any omission, falsification or misrepresentation of any item or response on this application or any attachment hereto is a sufficient basis for denying or revoking a license.

_____ _____

Applicant Signature Date

Signed on this _____ day of _____ , _____ at

Day Month Year

_____ , _____ , _____ .

City County State

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CERTIFICATE OF PREMEDICAL EDUCATION AND PODIATRIC MEDICAL EDUCATION

Official Transcripts of **ALL** premedical postsecondary **and** podiatric medical education must be submitted directly to the Board of Podiatric Medicine to be acceptable. This form must accompany your transcripts. Use one form for each colleges or universities attended. ***Transcript(s) must be mailed directly from the school to the Board to be acceptable.***

TO BE COMPLETED BY APPLICANT:

Please type or print.

Name: **Date of Birth:**

TO BE COMPLETED BY PODIATRIC MEDICAL SCHOOL:

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Name of college/university: _____

Address: _____

Date applicant enrolled in school: _____ ☐

Date applicant was issued the degree: _____ ☐

Title of degree awarded: _____ ☐

The undersigned further certifies that the records of this institution show that he/she attended in this institution _____ courses of resident instruction of _____ weeks each, completing at least 4,000 hours (of at least 50 minutes each) in the subjects set forth hereunder (Business and Professions Code Section 2483), and was granted the degree of Doctor of Podiatric Medicine by the above-mentioned podiatric medicine school on the _____ day of _____ _____. ☐

SUBJECTS OF INSTITUTION

Alcoholism and Substance Abuse Detection	Anesthesia	Anatomy (incl. Embryology, Histology and Neuroanatomy)	Behavioral Science
Biochemistry	Dermatology	Bacteriology, Infectious Disease	Podiatric Medicine
Biomechanics – Foot and Ankle	Didactic Podiatry	Pathology, Microbiology and Immunology	Podiatric Surgery
Child Abuse Detection	Geriatric Medicine	Pharmacology (incl. Materia Medica and Toxicology)	Physical Medicine
Psychiatric Problem Detection	Human Sexuality	Physical and Laboratory Diagnosis	Physiology
Orthopedic Surgery	Medical Ethics	Preventative Medicine (incl. Nutrition)	Therapeutics
Neurology	Pediatric Medicine	Physical Therapy	Women's Health

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

1. Did student ever take a leave of absence during medical school?	☐ Yes	☐ No	☐
2. Was student ever placed on probation?	☐ Yes	☐ No	☐
3. Was student ever disciplined or placed under investigation?	☐ Yes	☐ No	☐
4. Were any negative reports ever filed by student's instructor(s)?	☐ Yes	☐ No	☐
5. Were any limitations or special requirements imposed on student due to questions of academic or disciplinary problems, or for any other reason?	☐ Yes	☐ No	☐

A "yes" response to questions 1 – 5 requires a signed and dated letter of explanation by school official.

SCHOOL OFFICIAL CERTIFICATION

AFFIX SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct. ☐

PRINTED NAME OF SCHOOL OFFICIAL		TITLE OF SCHOOL OFFICIAL
SIGNATURE OF SCHOOL OFFICIAL		DATE

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that must be attached to this form. Such delegation must be on official letterhead and must be dated within the last 12 months.

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REQUEST FOR LETTER OF GOOD STANDING / LICENSE VERIFICATION BY STATE LICENSING AGENCY

If you held, or currently hold a doctor of podiatric medicine license (limited, resident or permanent) in another state, please request a letter of good standing/license verification. Use one form for each state agency where a license is held. ***Verification must be completed and mailed directly from the licensing agency to the Board to be acceptable.***

TO BE COMPLETED BY APPLICANT:

Please type or print.

Name:

Address:

City / State / Zip:

Telephone Number:	**Date of Birth:**

E-mail Address:

TO BE COMPLETED BY STATE LICENSING AGENCY:

BPM Use Only

State/Province:		**License Number:**		☐
Issue Date:		**Expiration Date:**		☐
Status:				☐

UNUSUAL CIRCUMSTANCES

1. Has the license ever been denied, restricted, suspended, terminated or revoked?	☐ Yes	☐ No	☐
2. Is there any action currently pending against the licensee?	☐ Yes	☐ No	☐

A "yes" response to questions 1 – 2 requires a signed and dated letter of explanation by state agency official.

STATE AGENCY OFFICIAL CERTIFICATION

AFFIX STATE SEAL

I certify that this license is valid, current, has never been suspended or revoked, and that records in this office indicate that there are not now, nor have there ever been any charges filed against the holder of this license.

PRINTED NAME OF AGENCY OFFICIAL		**TITLE OF AGENCY OFFICIAL**
SIGNATURE OF AGENCY OFFICIAL		**DATE**
PHONE NUMBER		**WEBSITE**

Note: If any portion of the above certification is deleted or modified, please attach an explanation.

☐

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CERTIFICATE OF APPROVED RESIDENCY PROGRAM TRAINING

Completion of this form will certify that the applicant referenced below has satisfactorily completed a period of podiatric residency training at this facility and that the applicant has acquired the skill and qualification necessary to safely assume the practice of podiatric medicine in California. Approved Podiatric Residencies Programs are those that have been fully approved by the Council on Podiatric Medical Education. ***Certification must be completed by each residency program and mailed directly from the residency program to the Board to be acceptable.***

TO BE COMPLETED BY APPLICANT:

Please type or print.

Name: **Date of Birth:**

TO BE COMPLETED BY RESIDENCY PROGRAM DIRECTOR:

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Name of Resident Program: _____

Name of Sponsoring Facility: _____ ☐

Address of Sponsoring Facility: _____

_____

Training start date: _____ (Date) **Training end date:** _____ (Date) ☐

Residency category: _____
RPR, POR, PPMR, PMSR, PSR-12, PSR-24, PSR024+, PM&S-24 OR PM&S-36

☐ Completed at least **two years** of this program, is making satisfactory progress and is expected to complete this program on _____ (Date) ☐

☐ Completed this program on _____ (Date)

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING

1. Has he/she ever received partial or no credit for a postgraduate training program?	☐ Yes	☐ No	☐
2. Has he/she ever taken a leave of absence or break from your training?	☐ Yes	☐ No	☐
3. Has he/she ever been terminated, dismissed or expelled from a program?	☐ Yes	☐ No	☐
4. Has he/she ever resigned from a program?	☐ Yes	☐ No	☐
5. Was he/she ever placed on probation for any reason?	☐ Yes	☐ No	☐

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UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING continued

6. Was he/she ever disciplined or placed under investigation?	☐ Yes	☐ No	☐
7. Were any incident reports ever filed against him/her?	☐ Yes	☐ No	☐
8. Were any limitations or special requirements placed upon him/her for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐ Yes	☐ No	☐
9. Has he/she ever had a postgraduate training program contract not be renewed or offered for a following year?	☐ Yes	☐ No	☐

Program Director: Please provide a signed and dated letter of explanation for any "yes" responses to questions 1 – 9. The explanation must be provided on program letterhead and mailed directly to the Board from the residency program with this form.

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

I, _____ certify that I am/was the program director
Print Full Name of Residency Program Director

for the above named resident during the residency program dates indicated and that I have carefully read and completed this certification and that the statements made herein are strictly true in every respect.

_____ _____
Signature of Program Director Date

_____ _____
Email Telephone

Attention Program Director: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANTS BY BLOOD, MARRIAGE OR ADOPTION. Only the Residency Program Director may sign this form. If the signature is being delegated to another person, evidence of that must be attached to this form. Such delegation must be on official letterhead and must be dated within the last 12 months.

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REQUEST FOR AMERICAN PODIATRIC MEDICAL LICENSING EXAMINATION (APMLE) PART I and II CERTIFIED SCORES

INSTRUCTIONS: Applicants for licensure who need to have American Podiatric Medical Licensing Examination (APMLE) Part I & Part II scores certified to California may, by completing this form and including a check or money order in the amount of $35 payable to The National Board of Podiatric Medical Examiners (NBPME), request that The National Board of Podiatric Medical Examiners certify the score. Alternatively, APMLE Part I & Part II score reports can also be requested online at www.apmle.com.

Send this form and payment by regular mail (do not send certified or express mail) to:

PROMETRIC/NBPME
7941 Corporate Drive
Nottingham, MN 21236

Name:	
Address:	
City / State / Zip:	
Telephone Number:	Social Security Number:
E-mail Address:	
Date DPM Degree Conferred:	

FPMB: Please send certified scores to:

CALIFORNIA BOARD OF PODIATRIC MEDICINE
2005 Evergreen Street, Suite 1300
Sacramento, CA 95815

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REQUEST FOR AMERICAN PODIATRIC MEDICAL LICENSING EXAMINATION (APMLE) PART III (PMLEXIS) CERTIFIED SCORE REPORT

INSTRUCTIONS: Applicants for licensure who need to have American Podiatric Medical Licensing Examination (APMLE) Part III (PMLexis) score certified to California may, by completing this form and including a check or money order in the amount of $45 payable to the FPMB, request that the Federation of Podiatric Medical Boards certify the score. Alternatively, APMLE Part III score reports can also be requested online at www.fpmb.org.

Send this form and payment by regular mail (do not send certified or express mail) to:

FEDERATION OF PODIATRIC MEDICAL BOARDS
12116 Flag Harbor Drive
Germantown, MD 20874-1979

Name:	
Address:	
City / State / Zip:	
Telephone Number:	Social Security Number:
E-mail Address:	
State where Part III (PMLexis) was taken:	Date Part III (PMLexis) was taken:

FPMB: Please send certified scores to:

CALIFORNIA BOARD OF PODIATRIC MEDICINE
2005 Evergreen Street, Suite 1300
Sacramento, CA 95815

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MEMORANDUM OF UNDERSTANDING FOR APPROVED RESIDENCY PROGRAM PARTICIPATION

I, _____ have accepted a residency with _____. I am fully aware that the residency program is an approved program with the Council on Podiatric Medical Education, thereby meeting the postgraduate training requirements for licensure in California.

I am further aware that after completing a licensure application and meeting all the licensure requirements, I will be issued a resident's license by the Board of Podiatric Medicine for practice only in the above-designated residency program. Should I leave the program at any time prior to the expiration date of the resident's license, I will upon that date of departure surrender my resident's license to the Board of Podiatric Medicine. I am entering this program with the full knowledge that if I should not satisfactorily complete the program, no time spent in the postgraduate training program will be credited towards the California licensure requirement.

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)

_____ _____
Signature Date

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MEMORANDUM OF UNDERSTANDING FOR "*CANDIDATE STATUS*" RESIDENCY PROGRAM PARTICIPATION

I, _____ have accepted a residency with _____. I am fully aware that the residency program has only "***candidate status***" with the Council on Podiatric Medical Education, and that there is no assurance the program will be formally approved, thereby meeting the postgraduate training requirements for licensure in California.

I am further aware that after completing a licensure application and meeting all the licensure requirements, I will be issued a resident's license by the Board of Podiatric Medicine for practice only in the above-designated residency program. Should the program at any time be notified that it will **not** be approved by the Council on Podiatric Medical Education, I will upon that date surrender my resident's license to the Board of Podiatric Medicine. I am entering this program with the full knowledge that if the program should **not** be approved by the Council on Podiatric Medical Education, or if that approval is **not** retroactive to the time period in which I was a program participant, no time spent in the postgraduate training program will be credited towards the California licensure requirement.

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)

_____ _____
Signature Date

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