



**APPLICATION FOR PODIATRIC MEDICINE
X-RAY ASSISTANT
TRAINING COURSE AND EXAMINATION
PROVIDER APPROVAL**

Mail To: Board of Podiatric Medicine
Post Office Box 6330
Tallahassee, FL 32314-6330
(850) 245-4355
<http://floridaspodiatricmedicine.gov/>

PROFILE DATA: (PLEASE PRINT OR TYPE)

1. PROVIDER NAME: _____
(Name of Entity or provider)

CONTACT/COORDINATOR: _____

MAILING ADDRESS: _____
(Street and Number) (Box #) (City) (State) (Zip)

TELEPHONE: (____) _____ (____) _____
Business: Area Code/Phone Number **Fax: Area Code/Phone Number**

EMAIL ADDRESS: _____

(Email Notification: If you want to be notified of the status of your application by email please check the “YES” box below and write the course provider’s email address on the line provided above. If you choose this form of notification you will only receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the board office at MQA.PodiatricMedicine@flhealth.gov . Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

YES NO

• **Provider Type:**

School or College of Podiatric Medicine
(must submit proof of accreditation by
the Council on Podiatric Medical Education)

Commercial Educator

Governmental Agency

State or National Podiatric Professional Association

2. COURSE INFORMATION:

• **Course Type:**

Live Correspondence

• **Number of hours (must be a minimum of ____):** _____

• **What is the minimum passing score for the examination?** _____

• **Name of Program Director, if different than Coordinator (attach resume):**

(Last)

(First)

(State License #, if any)

- **Personnel/Instructors Roster (if applicable):**

Last Name	First Name
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3. APPLICANT SIGNATURE:

I state that these statements are true and correct and recognize that providing false information may result in criminal penalties pursuant to Sections 456.067, 775.082, 775.083, and 775.084, Florida Statutes.

I understand that Florida law requires a supplement to this application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board of Podiatric Medicine's decision concerning eligibility for course approval.

Syllabus and course materials must be attached to this submission.

SIGNATURE: _____ DATE: _____