PODIATRIC RESIDENT HOSPITAL PROGRAM REPORT

PROGRAM DIRECTOR ----- Each new resident must complete the Podiatric Resident Registration form DH-MQA 1139, a copy of which must be attached to this report.

DO NOT REPORT "LICENSED RESIDENTS" ON THIS FORM

ANNUAL PERIOD: ______________________**THRU**_____________________________

NAME OF REPORTING HOSPITAL: ____

PROGRAM DIRECTOR: _________________________ **Telephone Number (   )** ______________

Program Address: ____________________________________

____

Mailing: ______________________________________

____

EMAIL ADDRESS: ____

Section A – Podiatric Physicians on staff or who otherwise serve in a supervisory position:

NAME LICENSE #

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(Attach supplemental list as needed)

Section B – Podiatric Residents beginning residency during this reporting period. (Please note that if a podiatric resident was listed in this area last reporting period, they are not listed here again but listed in Section C):

NAME RESIDENCY BEGINS RESIDENCY ENDS

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(Attach supplemental list as needed)

Division of Medical Quality Assurance - Board of Podiatric Medicine
4052 Bald Cypress Way, Bin #C07 - Tallahassee, FL 32399-3257
www.doh.state.fl.us/mqa/podiatry
(850) 245-4355

Section C – Podiatric Residents continuing in residency:

NAME	RESIDENCY BEGAN	RESIDENCY ENDS

(Attach supplemental list as needed)

Section D – Podiatric Residents who completed residency:

NAME	RESIDENCY BEGAN	RESIDENCY ENDED

(Attach supplemental list as needed)

Section E – Podiatric Residents who have withdrawn:

NAME	RESIDENCY BEGAN	RESIDENCY ENDED

(Attach supplemental list as needed, indicate status with regard to rights and qualifications for readmission)

ATTACH COPY OF HOSPITAL'S MOST RECENT RESIDENCY PROGRAM EVALUATION BY THE COUNCIL ON PODIATRIC MEDICAL EDUCATION

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Signature of Program Director   Date

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