Complete forms must be submitted to
info@floridaspodiatricmedicine.gov or mailed to:

Board of Podiatric Medicine
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257

Board of Podiatric Medicine
Podiatric Resident Hospital Program Report Form

Do not report "Licensed Residents" on this form.

1. REPORTING INFORMATION

Annual Period: From: July 1st __________ To: June 30th __________
YYYY YYYY

Reporting Hospital: ______________________________

Program Director: ______________________________ Telephone: ______________

Email Address: ______________________________

Program Address: ______________________________
Street and Number City State ZIP

Mailing Address: ______________________________
Street and Number City State ZIP

2. SUPERVISING PHYSICIANS

List all podiatric physicians on staff or who otherwise serve in a supervisory position. Attach additional sheets if necessary.

Podiatric Physician Name	License #

3. NEW RESIDENTS

List all podiatric residents beginning residency during this reporting period. Do **not** list any podiatric residents who were listed in this section last reporting period. Attach additional sheets if necessary.

Podiatric Resident Name	Date Residency Begins (MM/DD/YYYY)	Date Residency Ends (MM/DD/YYYY)

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

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4. CONTINUING RESIDENTS

List all podiatric residents continuing in residency. Attach additional sheets if necessary.

Podiatric Resident Name	Date Residency Began (MM/DD/YYYY)	Date Residency Ends (MM/DD/YYYY)

5. RESIDENCY COMPLETION

List all podiatric residents who have completed residency. Attach additional sheets if necessary.

Podiatric Resident Name	Date Residency Began (MM/DD/YYYY)	Date Residency Ended (MM/DD/YYYY)

6. RESIDENCY WITHDRAWN

List all podiatric residents who have withdrawn from the residency program. Attach additional sheets if necessary.

Podiatric Resident Name	Date Residency Began (MM/DD/YYYY)	Date Residency Ended (MM/DD/YYYY)

Attach a copy of the hospital's most recent residency program evaluation by the Council on Podiatric Medical Education.

Program Director Signature: ______________________________ Date: ______________
MM/DD/YYYY