PODIATRIC RESIDENT REGISTRATION

(This form must be completed and attached to the Podiatric Resident Hospital Report then forwarded to the board office within 60 days of commencement of residency)

Name of Resident: ____

Resident's Address: ____

____

Telephone Number: ____

Email Address: ____

Date of Birth: __________

EQUAL OPPORTUNITY DATA:
Your furnishing of the information below is voluntary. We are required to ask that you furnish this information as part of your voluntary compliance with Section 2-Uniform Guidelines on Employee Selection Procedure 43FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for certification.

Race: _____ White _____ Black _____ Hispanic _____ Asian/Pacific Islander

_____ Native American ______Other (Specify race here)

Sex: _____ Male _____ Female

DPM Degree received from: ____
(An official final transcript must be sent from college directly to Board office)

Date Degree received: ____________________

Are you licensed to practice Podiatry in any state or foreign country? __________
If yes, each state must complete the attached verification form and submit it directly to the Board office.

Program Information

Name of Hospital: ____

Program Director's Name: ____

Telephone Number: ________________________ Email Address: ___________________________

Mailing Address: ____

____

Date Residency Starts: __________________________
Month/Day/Year

Date Residency Ends: ___________________________
Month/Day/Year

Applicant Name: ____

1. **GENERAL HISTORY:** [Attach additional sheet(s) if necessary]

a. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction or have you ever been a defendant in a military court-martial? Do not include parking or speeding violations. Yes _____ No _____

If yes, please list date, jurisdiction (state and county), offense, disposition and all relevant information:

____

____

b. Have you ever been the subject of any disciplinary action by the licensing authority of any state or are you the subject of any pending investigation or disciplinary action? Yes _____ No _____

If yes, provide details: ____

____

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes.. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? Yes ______No ______ ? **(If you responded NO, skip to 3)**

a. If “yes” to 2, for felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation? Yes ______No ______

b. If “yes” to 2, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes). Yes ______No ______

c. If “yes” to 2, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? es _____ No _____

d. If “yes” to 2, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? Yes ______No ______
(If “yes,” please provide supporting documentation)

3. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes ______No ______

a. If “yes” to 6, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? Yes ______No ______

4. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913,Florida Statutes? Yes ______No ______

NAME: ____

a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes ______No _______

5. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes _____No ______ **(If "No," do not answer 5a or 5b.)**

a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes _____ No ______

b. Did the termination occur at least 20 years before to the date of this application? Yes _____No _____

6. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? Yes _____No _____

As a reminder to all applicants, please understand that Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

I, ________________________________, certify the above information is true and correct.
Print Name

____
Signature of Registrant

LICENSE VERIFICATION

INSTRUCTIONS TO THE APPLICANT:

1. Complete the information in Part I only.
2. This form must be returned by the Board or agency which issued your license.

PART I: TO BE COMPLETED BY APPLICANT

Name:____DOB:__/__/_____
Address:___________________________
Title of License:__________________License No.:__________________

PART II: TO BE COMPLETED BY THE STATE BOARD OFFICE

The individual listed above has entered into a residency program in Florida. Before further consideration, we require the information requested on this form. The Board may submit their standard verification form in lieu of completing this form, as long as you indicate whether or not discipline has been taken against the license, and affix the Board seal.

Name:____
Title of License:______________________________________
Original Issue Date:___________________________________
License Number:_____________________________________

THIS LICENSE IS CURRENTLY:
[ ] Active [ ] Inactive [ ] Temporary [ ] Other (Explain)

THIS LICENSE WAS OBTAINED BY:
[ ] Examination [ ] Grandfathering [ ] Reciprocity/Endorsement

ACTION TAKEN AGAINST LICENSE:
[ ] No Disciplinary Action Taken [ ] Disciplinary Action Taken*
(*If disciplinary action was taken, please provide documentation)

Signature:______________________________Title:____________________________

Date:__________State Board:_______________Please Affix Board Seal

* If disciplinary action has been taken against this licensee, please provide our office with any documentation regarding the disciplinary action.

Florida HEALTH

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Board of Podiatric Medicine

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Name: ____

Last **First** **Middle**

Social Security Number: ________________________________

APPLICANT HISTORY: (**If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)**

1. **In the last five years**, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse? [ ] YES [ ] NO

2. **In the last five years**, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? [ ] YES [ ] NO

3. **During the last five years**, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice podiatric medicine? [ ] YES [ ] NO

4. **During the last five years**, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice podiatric medicine? [ ] YES [ ] NO

5. **In the last five years**, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? [ ] YES [ ] NO

6. **During the last five years**, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice podiatric medicine?
[ ] YES [ ] NO