# CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

**Florida Department of Health**
**Board of Podiatric Medicine**

**Name:** ______________________________________________________
**Last** **First** **Middle**

**Social Security Number:** ______________________________________

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.

## FLORIDA BOARD OF PODIATRIC MEDICINE
## CERTIFIED PODIATRIC X-RAY ASSISTANT

# UPDATE SUPERVISOR FOR CERTIFIED PODIATRIC X-RAY ASSISTANT

**INSTRUCTIONS:**
**The application must be completed in its entirety. All parts of the application should be legibly written or typed.**

If you would like a duplicate license providing the updated information, please return the application and fee of $25 (certified check or money order) to:

Department of Health
Board of Podiatric Medicine
Post Office Box 6330
Tallahassee, Florida 32314-6330

**NOTE:** Please make check payable to the **Department of Health**.

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**1. APPLICATION PROFILE DATA: Please print or type**
(To be completed by licensee)

LICENSE #:___________________

(Name) Last | First | Middle

(Address) Street Number | Apt/Suite Number

City | State | Zip Code

Home Telephone Number | Business Telephone Number

Date of Birth

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**2. (THIS SECTION TO BE COMPLETED BY EACH PODIATRIC PHYSICIAN WHO WILL SUPERVISE ASSISTANT) PLEASE MAKE COPIES IF NECESSARY.**

[ ] Individual Application
[ ] Group Application

3. **DATA ON PODIATRIC PHYSICIAN WHOM YOU PLAN TO WORK UNDER. [IF GROUP PRACTICE USE NAME OF THE PRESIDENT OR MANAGING PARTNER]:**

Name of Group

(Name) Last First Middle (Podiatric Physician License Number)

(Address Where Assistant is Employed) Street Number Apt/Suite Number

City State Zip Code

Home Telephone Number Business Telephone Number

Date of Birth

**APPLICANT SIGNATURE**

I, the undersigned, state that I am the person referred to in this application for licensure in the State of Florida.

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

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instruments (local, state, federal or foreign) to release to the Department of Health, any information, files and/or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organization, individuals, and groups listed above, any information which is material to my application.

I understand that Florida law requires me, as an applicant for licensure, to supplement my 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 my eligibility for licensure. (Section 456.013, Florida Statutes) Failure to do so may result in action by the Board including denial of licensure.

I further state that I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I understand that such action shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida in the profession for which I am applying.

I also state that I will comply with all requirements for licensure renewal in effect at the time of license renewal, including submission of appropriate renewal fees and completion of required continuing education credits.

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.

Podiatric X-Ray Assistant Signature (required) Date Signed

Supervising Physician Signature (required) Date Signed