

# Podiatric X-Ray Assistant Application for Training Course and Examination Provider Approval



**Board of Podiatric Medicine  
P.O. Box 6330**

**Tallahassee, FL 32314-6330**

**Website: [www.floridaspodiatricmedicine.gov](http://www.floridaspodiatricmedicine.gov)**

**Email: [info@floridaspodiatricmedicine.gov](mailto:info@floridaspodiatricmedicine.gov)**

**Phone: (850) 245-4292**

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## Provider Type:

School or College of Podiatric Medicine *(Recognized and approved by the Council on Podiatric Medical Education)*

Commercial Educator

Governmental Agency

State or National Podiatric Medical Professional Association

## 1. PROVIDER INFORMATION

Provider Name: \_\_\_\_\_  
(Name of Entity or Provider)

Contact/Coordinator: \_\_\_\_\_

### Mailing Address:

Street/P.O. Box \_\_\_\_\_ Box. No. \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_ Country \_\_\_\_\_ Telephone (Input without dashes) \_\_\_\_\_

**Email Notification:** To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes      No      Email Address: \_\_\_\_\_

Under Florida law, email addresses are public records. If you do not want your email 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.

## 2. COURSE INFORMATION

A. Course Type:      Live      Home Study

B. Number of hours (must be a minimum of \_\_\_\_): \_\_\_\_\_

C. Minimum passing score for the examination: \_\_\_\_\_

D. Name of Program Director, if different than Coordinator:

\_\_\_\_\_  
Last/Surname                                      First                                      State License #, if any

Name: \_\_\_\_\_

### 3. INSTRUCTOR INFORMATION

Name: \_\_\_\_\_  
Last/Surname First Middle

Name: \_\_\_\_\_  
Last/Surname First Middle

Name: \_\_\_\_\_  
Last/Surname First Middle

**The following must be attached to this submission:**

Syllabus

Course materials

Resume or CV of instructor(s)

### 4. COORDINATOR SIGNATURE

I affirm that these statements are true and correct and recognize that providing false information may result in criminal penalties pursuant to section 456.0671 Florida Statutes.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of approval and to supplement the information on this application as needed.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
*You may print out the application and sign it or sign digitally.* MM/DD/YYYY