Complete forms must be sent directly from the supervisor to info@floridaspodiatricmedicine.gov or mailed to:

Board *of* Podiatric Medicine
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Board *of* Podiatric Medicine
Certified Podiatric X-Ray Assistant Update Supervisor Form

Part I: To be completed by licensee

Name: _____

Address: _____
Mailing Address City State ZIP

Home/Cell Telephone: _____ Work/Cell Telephone: _____

License Number: _____

Part II: To be completed by each Podiatric Physician who will supervise assistant(s)
(Make copies if necessary.)

☐ Individual Application ☐ Group Application

Part III: Supervising Podiatric Physician Data
(If group practice, use name of the president or managing partner.)

Name of Group: _____

Name: _____

Address: _____
Practice Location City State ZIP

Telephone: _____ License Number: _____

Applicant Signature _____ Date _____
MM/DD/YYYY

Supervising
Physician Signature _____ Date _____
MM/DD/YYYY

To receive a duplicate license displaying the updated information, please return with fee of $25.00. Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health.

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