Applicant Name: _____

SUPERVISING PHYSICIAN INFORMATION

This section must be completed by each podiatric physician who will be supervising the assistant.

Name of Physician Group: _____

Supervising Physician: _____
Last/Surname First Middle

Podiatric Physician License Number: _____ **Date of Birth:** _____
MM/DD/YYYY

Email Address*: _____

Address Where Assistant is Employed:

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____
State ZIP Business Telephone Number

* 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.

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 s. 456.067, F.S.

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 processing 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 any when any material change in any circumstances or conditions occur which might affect the Board of Podiatric Medicine's decision concerning my eligibility for licensure (s. 456.013, F.S.). 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 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 s. 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
MM/DD/YYYY

Supervising
Physician Signature _____ Date _____
MM/DD/YYYY