# Board of Podiatric Medicine

2829 University Avenue S.E., Suite 430 • Minneapolis, MN 55414-3245
Phone: (612) 548-2175 • Fax: (612) 617-2698
www.podiatricmedicine.state.mn.us

## APPLICATION FOR LICENSURE

### GENERAL INFORMATION AND REQUIREMENTS

Please read the directions carefully. If additional information is required, contact the Minnesota Board of Podiatric Medicine at (612) 548-2175.

This application includes the following:

- General Information and Requirements
- Application for Licensure
- Personal Recommendation Form
- Verification of Licensure Form

**Requirements/Documentation**

Provide all of the documentation listed for each requirement, in addition to completing the application form. License requirements are summarized below:

- Graduation from one of the accredited colleges of podiatric medicine.

  Official transcript of your DPM degree, including date of graduation, signature of a college official, and original seal is required. Photocopies are not acceptable. No other transcripts are required. Transcripts must be received at the Board office directly from the educational institution.

- Passing score on each part of the National Board examinations, Part I and Part II. (Note: as of August 2004, completion of the National Board examination Part III (PMLexis) is no longer required.)

To request official copies of your National Board examinations Part I and Part II test results, you may print the request form from the American Podiatric Medical Licensing Examination website at www.apmle.com or contact Prometric, at ATTN: NBPME, 7941 Corporate Drive, Nottingham, MD 21236, telephone (877) 302-8952. Test scores must be received at the Board office directly from them.

- Recommendation from a DPM licensed in Minnesota or other state with personal knowledge of your skills and abilities to practice podiatric medicine.

- Verification of licensure in all states or countries in which a license was held.

  If licensed by more than one state, photocopy the attached form (attachment B), complete the "Applicant" portion, and send it to each state that has issued a license to you. Verification of licensure must be received at the Board office directly from each state in which a license was held.

- If licensed in another state: provide evidence of pro-rata compliance with continuing medical education requirements in that state and evidence of professional liability insurance coverage and claims history.

- DPM degree granted after 1986: Clinical residency programs must be approved by the Council on Podiatric Medical Education (CPME). Verification of successful completion of the CPME approved clinical residency must be received at the Board office directly from the clinical residency.

- If you entered a residency after June 30, 1995, your documentation must include written verification from your program supervisor that you have completed the program and you must submit your surgical and other training logs to the Board office. These logs will be returned to you at your request.
- If your name has changed, include official documentation of your new name and your former name.
- Application fee: $660 for two years of licensure, which includes a 10% e-licensing surcharge of $60. Note: your first renewal fee and required CME's will be prorated to account for the months of the two-year renewal period the license was held.

**Personal Appearance/Jurisprudence Quiz and your surgical and/or training logs**
When all application materials have been received at the Board office, you may contact the Board office to set up a time to complete the personal interview and jurisprudence exam.

In the interview, your application and your surgical and/or training logs will be reviewed and the jurisprudence exam will be reviewed. The jurisprudence quiz is an open book exam with questions relating to Minnesota laws governing the practice of podiatric medicine; rules regarding continuing education requirements; data privacy regulations, grounds for disciplinary actions, rules adopted for infection control; laws governing the establishment and operation of examining and licensing boards; HIV, HBV and HCV reporting requirements, and the Minnesota Health Professionals Services Program (HPSP).

The required reference materials to complete the exam may be downloaded from the web site.

**Business Address**
Minnesota Statutes §214.073 requires licensees to provide their primary business address at the time of initial application and all subsequent renewals.

**Issuance of the License to Practice Podiatric Medicine**
When all requirements have been met, your license to practice podiatric medicine will be issued.

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## APPLICATION FOR LICENSURE

This application is authorized by MN Statutes section 153 and will be used to determine your qualifications for licensure. Although you are not legally required to supply the information requested in this application, failure to supply the information could result in the denial of your application. If you supply the information requested and it shows you do not meet the requirements for licensure, your application could be denied. Further, if the information shows you have engaged in conduct prohibited under MN Statutes section §153.19, subd. 1, the Board may initiate an investigation before acting on your license application and/or may deny your application or issue a conditional or limited license.

The information you supply will become part of your permanent file. Except for your social security number and Minnesota business identification number, this file becomes a public record when licensure is granted. Until licensure is granted, the information you supply, except for your name and address, is classified as private data, accessible only to you, the Board of Podiatric Medicine, its employees and agents, and employees and agents of the Minnesota Attorney General's Office representing the Board. (Reference MN Statutes section §13.355, subd. 1 and section§13.41, subd. 5.) In accordance with law, application information may also in some circumstances be disclosed to certain other persons or entities, including the Office of Administrative Hearings and any reviewing court.

Falsification of application information provides grounds for denial of a license.

| Name (Last, First, Middle) Previous or former name<br><br>**Note: If you have changed your name, include documentation of the name change as part of your application.** | Phone No.<br>Home:<br>Cell:<br>Pager: |
|---|---|
| Street Address – Work | City, State, Zip |
| Street Address – Home | City, State, Zip |
| Email Address | Social Security No. |
| Date of Birth | Gender |
| Drug Enforcement Agency (DEA) No. (if applicable) | Federal Tax ID No. (if applicable) |
| Intended Podiatric Practice Location in Minnesota | Minnesota Business Tax ID No. (if applicable) |
| College of Podiatric Medicine Attended | Graduation Date (Month/Day/Year) |

***Note:*** ***<u>The Board must receive a complete, official transcript of your education directly from the educational institution. The transcript must contain the date of graduation, the degree granted and an original seal of the college.</u>***

***For Office Use Only:***

| Application Fee $660<br>Reinstatement Fee $650<br>Check #: | Date paid: | Deposit #: | Interviewed by: | MN License #: | Date issued: |
|---|---|---|---|---|---|

**National Board of Podiatric Medical Examiners Examination:**

| Part I | Date Completed: |
|---|---|
| Part II | Date Completed: |

***Note: Official copies of your scores including an original seal are to be forwarded directly to the Board office.***

**List all states and countries in which you have held a podiatric medicine license or permit:**

| State | License No. | Current Status |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

***Note: If you have been licensed in other states or countries, request from each that a Verification of Licensure form be sent directly to the Board office using Attachment B. In addition, out-of-state applicants must complete Attachment D to demonstrate pro-rata compliance with continuing medical education requirements in the current state of licensure.***

**Information about the DPM submitting a personal recommendation for you:**

| Name of Podiatrist: | State in which licensed: |
|---|---|
| Address | City, State, Zip |

***Note: The recommending DPM must submit the personal recommendation (attachment A) with an original signature directly to the Board office.***

**Applicants graduating in 1987 and thereafter from a podiatric medical school must present evidence of satisfactory completion of acceptable graduate training. Applicants entering a graduate training program after June 30, 1995 must provide evidence of satisfactory completion including written verification from the program supervisor and submission of the applicant's surgical and other training logs.** ***Check the type of program completed and provide the dates of the training:***

I completed a Clinical Residency that was approved by the Council on Podiatric Medicine ___________

The dates of the training were from ______________________________ to ______________________________
Month/day/year Month/day/year

Name of sponsoring institution: ____________________________________________________________________

Address: _____________________________________________________________________________________

***Note: Your program supervisor must submit written verification with an original signature directly to the Board office indicating completion of this program. (A photocopy or a fax of your completion certificate does not meet this requirement.)***

**For applicants licensed in another state, provide the following information for the past five years:**

| Name of Professional Liability Insurer | Terms of Policy<br>From: To: |
|---|---|
| Name of Professional Liability Insurer | Terms of Policy<br>From: To: |

***Note: Verification of your insurance coverage and claims history is to be forwarded directly to the Board from your insurance company.***

**Date, disposition and number of malpractice award(s) or settlement(s) relating to podiatric medical treatment in the past five years. *If none, indicate "None."***

| Disposition | Date of Disposition |
|---|---|
| | |
| | |

**Conduct and Ability to Practice: (If the answer to any of the questions listed below is "Yes," please explain in the space provided, or attach additional documentation, as needed.)**

1. ☐ Yes ☐ No Have you ever been denied a license to practice podiatric medicine?

2. ☐ Yes ☐ No Have you been convicted of a felony during the past five years?

3. ☐ Yes ☐ No Are you currently charged with a felony or, to your knowledge, under investigation by any federal, state or local law enforcement authority?

4. ☐ Yes ☐ No Have you ever had a license to practice podiatric medicine revoked, suspended, restricted, limited, or had any other disciplinary action taken against a license to practice podiatric medicine in any other state or jurisdiction?

5. ☐ Yes ☐ No Have you ever surrendered a license to practice podiatric medicine or allowed a license to practice podiatric medicine to lapse or expire prior to the conclusion of any investigation or disciplinary proceedings?

6. ☐ Yes ☐ No To your knowledge, are you currently the subject of any formal or informal legal, administrative, or disciplinary proceeding or investigation by any court or regulatory authority concerning your conduct, qualifications or ability to practice as a health professional?

7. ☐ Yes ☐ No Have you ever been denied a DEA certificate (federal registration to administer, prescribe or dispense controlled substances) or ever had a DEA certificate revoked or suspended?

8. ☐ Yes ☐ No Has your DEA certificate (if held) ever been restricted, limited or conditioned or have you ever surrendered a DEA certificate?

9. ☐ Yes ☐ No Have you ever been denied or lost privileges to practice or treat patients in a health care facility or have you resigned prior to the conclusion of any investigation or disciplinary proceeding?

10. ☐ Yes ☐ No Have you ever been a party to a malpractice settlement or award pertaining to the practice of podiatric medicine or are you currently responding to or litigating any malpractice insurance claims?

11. ☐ Yes ☐ No Have you ever been adjudicated by a court as mentally incompetent, a person dangerous to the public, a sexually dangerous person, or a person who has sexual psychopathic personality?

12. ☐ Yes ☐ No Within the past five years, have you been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice podiatric medicine with reasonable skill and safety?

If you answered this question affirmatively, please answer the following:

a. ☐ Yes ☐ No With regard to any condition referenced above, are you being treated so that such impairment is avoided?

b. ☐ Yes ☐ No With regard to any condition referenced above, are you in compliance with the recommended treatment?

c. ☐ Yes ☐ No With regard to any condition referenced above, has your treating physician advised you that you are able to practice podiatric medicine with reasonable skill and safety?

Please explain and identify your treating physician: ___________________________

Address: ________________________________________________________________

***Note: If any answers to the foregoing questions change while the application is pending, the applicant is required to provide updated information to the Board.***

The undersigned does hereby affirm that the statements contained in this application are true and correct.

____________________________________________

Signature of Applicant

____________________________________________

Date

Subscribed and sworn to before me this _____________day of ______________________________, 200__

State of___________________________

County of_________________________

____________________________________________

Signature of Notary Public

Notary Seal or Stamp

My commission expires:

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## PERSONAL RECOMMENDATION *Attachment A*

Applicant's Name: ______________________________________________________________________

**Instructions: The applicant named above has requested that you to provide a personal recommendation. Please fill in the requested information as shown below:**

1. How long have you known the applicant? ______________________________________________

2. In what settings have you had an opportunity to observe the skills and abilities of the applicant to practice podiatric medicine? ______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

3. How would you characterize the moral conduct, professional conduct and professional ability of the applicant?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

4. Would you recommend that the applicant be granted a license for the independent, unrestricted practice of podiatric medicine? _______ If not, please explain ______________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

5. Additional comments: ______________________________________________________________
______________________________________________________________________
______________________________________________________________________

Completed by:

Name: ______________________________________________________________________

Address: ____________________________________________________________________
*Street address* *City* *State* *Zip code*

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## VERIFICATION OF LICENSURE *Attachment B*

**Instructions: Forward this form to all states or countries that have issued a license to you.**

***Applicant to complete this section:***

| Name | Former Name |
|---|---|
| Current Address | City, State, Zip |
| College of Podiatric Medicine Attended | |
| License Number | Date Issued |

***Licensing agency to complete this section:***

### License Verification

The above named person was issued license number___________________, to practice podiatric medicine, effective this date__________________

License expiration date______________________

Licensed by:
- ☐ Examination
- ☐ Endorsement
- ☐ Waiver

Current licensure status:
- ☐ Active
- ☐ Inactive
- ☐ Lapsed

Has this license ever been revoked, suspended, surrendered, restricted, limited, placed on probation, or otherwise encumbered? ☐ Yes ☐ No Explain a "Yes" response:

Signature___________________________________________ Date_________________________

Title_______________________________________________ State ________________________

**Seal**

***Upon completion, this form is not be returned to the applicant, but is to be forwarded <u>directly to the Minnesota Board of Podiatric Medicine</u> at the address shown above.***

## WORK HISTORY *Attachment C*

**Please describe your major work history below:**

***Experience 1***
Facility Name ____________________________________________

Facility location: __________________________________________
City State

Your title/duties: __________________________________________

Hours per week _________

Licensed as: _______

Employment dates: _____/_____ to _____/_____
Month/year Month/year

***Experience 2***
Facility Name ____________________________________________

Facility location: __________________________________________
City State

Your title/duties: ___________________________________________

Hours per week _________

Licensed as: _______

Employment dates: _____/_____ to _____/_____
Month/year Month/year

***Experience 3***
Facility Name: ____________________________________________

Facility location: __________________________________________
City State

Your title/duties: ___________________________________________

Hours per week _________

Licensed as: _______

Employment dates: _____/_____ to _____/_____
Month/year Month/year

**RECORD OF CONTINUING EDUCATION *<u>Attachment D</u>***
***(Add additional sheets as needed)***

Out-of-state applicants with an active license in another state seeking licensure in Minnesota must demonstrate pro-rata completion of the continuing medical education requirements in the current state of licensure.

Current state of licensure: ________________________________________

Current period of licensure: __________________ to __________________
Month/day/year Month/day/year

Hours of continuing medical education required in the current state of licensure: _____

*If the license is inactive, the out-of-state applicant must submit with the license application evidence of participation in one-half the number of hours of acceptable continuing education required for biennial renewal, as specified under Minnesota Rules, up to five years. If the license has been inactive for more than two years, the amount of acceptable continuing education required must be obtained during the two years immediately before application or the applicant must provide other evidence as the board may reasonably require.*

**List courses completed in the space provided below. For each course listed, <u>include a copy of the course certificate</u> or a written statement of attendance from the sponsor including the name and dates of the program, the name and address of the sponsor, the number of continuing education clock hours granted by the sponsor, the name of the attendee, a signature of the sponsor or designee and the approval by the Council of Podiatric Medical Education or the Board of Podiatric Medicine in the current state of licensure**.

| Program/Course Title | Sponsoring Agency | Dates Month/Days/Year | Number of Hours |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Total Credit Hours** ____________________

*I certify that all continuing education information provided on this form is true and correct. I understand that providing false information may affect my application for licensure or may result in disciplinary action against my license to practice podiatric medicine in Minnesota.*

| **Signature:** | **Date:** |
|---|---|
| | |