Board of Podiatric Medicine

335 Randolph Avenue, Suite 210 • St. Paul, MN 55102
Phone: (612) 548-2175 • podiatric.medicine@state.mn.us
https://mn.gov/boards/podiatric-medicine/

APPLICATION FOR LICENSURE

GENERAL INFORMATION AND REQUIREMENTS

Requirements/Documentation

Provide documentation for each the following requirements, in addition to completion of the application form.

- The application fee is $600 and Criminal Background Check fee $32.00, totaling $632.00, and must be submitted with the application. Fees are non-refundable.
- An official DPM transcript must be received directly from the accredited college of podiatric medicine providing proof of graduation, including date of graduation, signature of a college official and original seal.
- Documentation of passing scores on the National Board Part I and Part II examinations must be received directly from them. Request official copies of test results from the American Podiatric Medical Licensing Examination website at www.apmle.com.
- Personal recommendation forwarded directly from a licensed DPM with personal knowledge of your skills and abilities to practice podiatric medicine.
- Verification of licensure from all states or countries in which a DPM license has been granted. License verification must be received directly from each state, either on the form included with this application or their official state verification form with the required information.
- Evidence of compliance with continuing medical education requirements, if licensed in another state.
- Professional liability insurance coverage, including a claims history, directly from the insurance carrier.
- Applicants graduating after 1986 from a podiatric medical school shall present evidence of successful completion of a residency program approved by the Council of Podiatric Medicine, which must be received directly from the program. Applicants who entered a residency program after June 30, 1995 must also submit surgical and other training logs, which will be returned upon request.
- If your name has changed, include official documentation of your new and former name.
- Personal Appearance/Jurisprudence Quiz - Upon receipt of all application materials, you may contact the Board office to schedule the required personal interview. The jurisprudence exam will be emailed to you for completion prior to the interview.

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The MN Board of Podiatric Medicine is seeking data from you which may be considered private or confidential under the MN Government Data Practices Act, Minn. Stat. §13.01 et seq. Minn. Stat. §13.04, subd. 2 requires the Board to notify you of the following four matters before you are asked to supply such information about yourself: (1) This data is being collected to determine whether you meet the requirements for licensure as well as whether you have violated any statutes or rules the Board is empowered to enforce; (2) You are not legally required to provide this information, but failure to do so may result in the denial of this licensure application; (3) If you supply the data requested and it shows a violation of any of the statutes or rules enforced by the Board, you may be subject to disciplinary or other action by the Board. If you refuse to supply the data requested, your licensure application may be denied. In addition, falsification or omission of information may be used by the Board as a basis for disciplinary action; and (4) the data which you supply will be accessible to Board staff. The data you supply may also be released to other persons and/or governmental entities that have statutory authority to review the data, investigate specific conduct, and/or take appropriate legal action. If the Board institutes a formal disciplinary action against you, the information you supply could become public.

APPLICATION FOR LICENSURE

Name (Last, First, Middle) Previous or former name **Note: If you have changed your name, include documentation of the name change as part of your application.**	Phone No. Home: Cell: 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)

For Office Use Only:

Application Fee $600 CBC Fee $32 Reinstatement Fee $650 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 a License Verification be sent directly to the Board office using Attachment B or their official form. In addition, out-of-state applicants must complete Attachment D to demonstrate 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 after 1986 from a podiatric medical school shall present evidence of successful completion of a residency program approved by the Council of Podiatric Medicine, which must be received directly from the program. Applicants who entered a residency program after June 30, 1995 must also submit surgical and other training logs, which will be returned upon request.

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: _____

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

Name of Professional Liability Insurer	Terms of Policy From: To:
Name of Professional Liability Insurer	Terms of Policy From: To:

Note: Verification of your <u>insurance coverage and claims history</u> 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. *<u>If none, indicate "None."</u>*

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, gross misdemeanor or misdemeanor during the past five years?

3. ☐ Yes ☐ No Are you currently charged with a felony, gross misdemeanor or misdemeanor, 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 Has your ability to practice podiatric medicine with reasonable skill and safety been in any way impaired or limited by your use of alcohol or chemical substances, including prescription medication, or has anyone expressed concern about your use of alcohol or chemical substances, including prescription medications?

13. ☐ Yes ☐ No Have you had a lapse of continuous practice of podiatric medicine of greater than two years since completion of your residency program?

14. ☐ 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_____

_____ Notary Seal or Stamp
Signature of Notary Public

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 directly to the Minnesota Board of Podiatric Medicine 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 *Attachment D*
(Add additional sheets as needed)

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: _____

List courses completed in the space provided below. For each course listed, include a copy of the course certificate 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.

If the license is active, the applicant shall submit with the license application evidence of compliance with the continuing education requirements in the current state of licensure.

If the license is inactive, the applicant shall submit with the license application evidence of participation in the same 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.

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:**