



# Board of Podiatric Medicine

2829 University Avenue S.E., Suite 430 • Minneapolis, MN 55414-3245

Phone: (612) 617-2200 • Fax: (612) 617-2698

www.podiatry.state.mn.us

## APPLICATION FOR TEMPORARY PERMIT

### INFORMATION AND INSTRUCTIONS

Please read the directions carefully. If additional information is required, you may contact Keith Hovland, Executive Director, at the Minnesota Board of Podiatric Medicine.

#### **General Information**

The Board may issue a temporary permit to practice podiatric medicine to a podiatrist engaged in a clinical residency, preceptorship or other graduate training in Minnesota. The applicant must have been accepted into a program that meets Board requirements. The scope of practice of the permit holder is limited to the performance of podiatric medicine within the structure of the program within which the permit holder is enrolled.

The permit is issued for a period of twelve months and may be renewed for valid reasons, with the sponsor's consent. The permit expires after twelve months or upon licensure. It is revoked if the applicant engages in conduct that constitutes grounds for denial of a license, discontinues training or moves out of Minnesota.

#### **Program Qualifications and Evidence Required**

##### **1. Clinical Residency**

The residence must be at least twelve consecutive months in length and be approved by the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association.

#### **Forward the following to the Board office:**

- Assurance that the residency is approved by the CPME
- Evidence of the beginning and ending dates of your residency
- A letter from the supervising podiatrist verifying your acceptance into the program
- Other information as specified on the application form

## 2. Preceptorship

The preceptorship must be at least twelve consecutive months in length, have written objectives appropriate to all training aspects of the program and must be operated under the control and supervision of an accredited college of podiatric medicine. The preceptor must:

- Have a practice that offers experience with the care of children and adults and in drug therapy, radiology, local anesthesia, analgesia, biomechanics, physical medicine, rehabilitation, and the following surgeries: 1) nail; 2) digital; 3) soft tissue; 4) forefoot; 5) metatarsal; 6) midfoot; and 7) rearfoot or ankle
- Hold a clinical appointment at a college or be a member of the teaching staff of a hospital sponsoring a residency program
- Have a hospital staff appointment with podiatric surgical privileges
- Not have been the subject of disciplinary action concerning professional conduct or practice

### **Forward the following to the Board office:**

- Proof that the preceptorship is under the control of a college of podiatric medicine
- A copy of the objectives and a description of the types of experience you will have
- A letter from the supervising preceptor that:
  - a. Verifies your acceptance into the preceptorship program
  - b. Specifies the college at which he/she holds a clinical appointment or the hospital at which he/she is a member of the teaching staff
  - c. Specifies the hospital at which he/she has a staff appointment and podiatric surgical privileges
- Evidence of the beginning and ending dates of your preceptorship
- Other information as specified on the application form

### **APPLICATION INSTRUCTIONS:**

- Complete the Application for Temporary Permit
- Request proof of acceptance into a post-graduate training program to be sent to the Board office
- Request other required documents to be sent to the Board office
- Send the Application for Temporary Permit and a check for \$250 to the Board of Podiatric Medicine, 2829 University Ave. SE, Suite 430, Minneapolis, MN 55414-3245

**Note:** For those applicants starting graduate training beginning on July 1, the application and all required documents should be received at the Board office early in the month of June so that the Temporary Permit can be issued before the start date of the post-graduate training program.



# Board of Podiatric Medicine

2829 University Avenue S.E., Suite 430 • Minneapolis, MN 55414-3245

Phone: (612) 617-2200 • Fax: (612) 617-2698

www.podiatry.state.mn.us

## APPLICATION FOR TEMPORARY PERMIT

This application is authorized by Minnesota Statutes 153 and will be used to determine your qualifications for a temporary permit. 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 a temporary permit.

The information you supply will become part of your permanent file. Except for your social security number, this file becomes a public record when the temporary permit is granted. Until the permit 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. In accordance with statutes and rules, 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 or omission of information provides grounds for denial of a permit.

Name (Last, First, Middle)	Previous	Phone No. Home: Cell: Pager:
Mailing Address		City, State, Zip
Email address		Social Security No.
Date of Birth (Mo/Day/Year)		Sex
Name of College of Podiatric Medicine		Graduation Date (Month/Day/Year)

**Note: 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 the original seal of the college.**

### National Board of Podiatric Medical Examiners Examination:

Part I	Date Completed:
Part II	Date Completed:

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

Application for Temporary Permit

*An Equal Opportunity Employer*

**Provide the following information about the podiatrist submitting a personal recommendation for you:**

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

**Your recommending podiatrist must complete the attached form and mail it directly to the Board office.**

**Please indicate the type of program for which you have been accepted:**

- Clinical Residency**                      Beginning:                      Ending:
- Preceptorship**                      Beginning:                      Ending:

**Complete the section corresponding to your answer shown above and provide documentation of acceptance into the post-graduate program.**

**Clinical Residency:**

Name of Sponsoring Institution
Address (street, city, state, Zip code)
Is this program currently approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name and Address of Supervising Podiatrist

**Preceptorship:**

Name of Supervising College of Podiatric Medicine
Address (street, city, state, Zip code)
Name and Address of Preceptor

Your preceptorship must complete the attached form and mail it to the Board office.

I hereby apply for a temporary permit to practice podiatric medicine in Minnesota under supervision while participating in a 12 month program of organized study. 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

**For Office Use Only:**

Permit Fee rcv'd \$	Date Paid	Deposit #
---------------------	-----------	-----------



# Board of Podiatric Medicine

2829 University Avenue S.E., Suite 430 • Minneapolis, MN 55414-3245

Phone: (612) 617-2200 • www.podiatry.state.mn.us

## PERSONAL RECOMMENDATION

Applicant's Name: \_\_\_\_\_

**Instructions: The applicant named above has requested that you to provide a personal recommendation. After you complete this form, please mail it directly to the Board of Podiatric Medicine at the address shown above.**

1. How long have you known the applicant? \_\_\_\_\_

2. What has been the nature of your relationship with the applicant?  
\_\_\_\_\_

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 temporary permit? If not, please explain.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Additional comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completed by:

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

Address:  
\_\_\_\_\_  
\_\_\_\_\_

States in which I hold current, active licenses:  
\_\_\_\_\_

Signature:  
\_\_\_\_\_

Date:  
\_\_\_\_\_

Application for Temporary Permit

*An Equal Opportunity Employer*



# Board of Podiatric Medicine

2829 University Avenue S.E., Suite 430 • Minneapolis, MN 55414-3245

Phone: (612) 617-2200 • www.podiatry.state.mn.us

## PRECEPTORSHIP

Name of Supervising College of Podiatric Medicine

Address (street, city, state, Zip code)

Does the program have written objectives appropriate to all training aspects of the program?  Yes  No  
If no, please explain.

In which of the following will the applicant receive practice?

- |  |  |
|--|--|
| <input type="checkbox"/> Nail surgery              | <input type="checkbox"/> Local anesthesia  |
| <input type="checkbox"/> Digital surgery           | <input type="checkbox"/> Analgesia         |
| <input type="checkbox"/> Soft tissue surgery       | <input type="checkbox"/> Radiology         |
| <input type="checkbox"/> Forefoot surgery          | <input type="checkbox"/> Biomechanics      |
| <input type="checkbox"/> Metatarsal surgery        | <input type="checkbox"/> Physical medicine |
| <input type="checkbox"/> Midfoot surgery           | <input type="checkbox"/> Rehabilitation    |
| <input type="checkbox"/> Rearfoot or ankle surgery | <input type="checkbox"/> Care of children  |
| <input type="checkbox"/> Drug therapy              | <input type="checkbox"/> Care of adults    |

I hereby verify that this applicant's study program is at least 12 months long, has written objectives and includes all aspects of podiatric medical care. I am or will be the applicant's preceptor and have never been the subject of disciplinary action concerning my professional conduct or practice.

Completed by:

Name:

---

Address:

---

Signature of Preceptor:

Date:

---

Upon completion, forward to the Board of Podiatric Medicine, 2829 University Ave. SE, Suite 430, Minneapolis, MN 55414-3245.

Application /temporary permit/ application for permit

Application for Temporary Permit

*An Equal Opportunity Employer*