



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF PODIATRY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

**PODIATRIC PHYSICIAN IN-TRAINING APPLICATION
INSTRUCTION SHEET**

Use this application if you are a Podiatric Physicians participating in a(n):

- Delaware in-state residency program, or
- out-of-state residency program that has a rotation of 45 days or longer in Delaware

Podiatrist In-Training licensees are limited to the practice of medicine within the hospital where they are employed except for any outside medical duties that may be assigned as part of the residency program. The outside duties must be performed under the supervision of a fully licensed podiatric physician.

Submit or have submitted to the Board Office:

- Application for Podiatric Physician In-Training Application*
- Processing fee by check or money order made payable to "State of Delaware" – see *Fee Schedule* at www.dpr.delaware.gov
- Official transcript sent directly from school to Board office
 - If you have not graduated at the time of application, provide a letter from the school attesting that you are in good academic standing, your expected completion date and your expected degree
- Official scores for the examinations that you have taken ([National Board of Podiatry Medical Examiners](#), [PMLExis](#))
- Verification of licensure from any state in which you currently hold, or have ever held, a license to practice podiatry, sent directly from the State Board to the Board office
- Residency Program Director's Affidavit* (included with application) completed and signed by your Resident Program Director and Supervising Physician



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PODIATRIC PHYSICIAN IN-TRAINING APPLICATION

IDENTIFYING AND CONTACT INFORMATION

1. Name: _____
Last First Middle Maiden

2. Address: _____
Street
City State Zip Code

3. Day Phone: _____ 4. Email: _____

5. Have you been issued a U.S. Social Security Number? Yes No
• If yes, enter your SSN: _____
• If no, you must file a *Request for Exemption from Social Security Number Requirement*.

6. Date of Birth: _____

EDUCATION AND EXAMINATIONS

7. Enter the following information about your medical school:

Name: _____ Department: _____

Graduation Date: _____ Check one: Actual Date or Expected Date

Address: _____

If you have graduated, arrange for your school to send an official transcript directly to the Board office. If you have not yet graduated, arrange for the school to send a letter directly to the Board office. The letter must attest that you are in good academic standing and include your expected completion date and degree.

8. Enter the following information about your residency:

Training Institution: _____ Department: _____

Address: _____
Street
City State Zip Code

Phone: _____ Date Training Expected to Begin: _____

If applicable, attach a list of hospital affiliations including the name and address of the hospital and the dates of service.

9. Have you taken and passed the National Board of Podiatric Medical Examiners' examination Parts I, II, and III? Yes No If yes, complete the following:

Examination	Score	Exam Date
NBPME Part I		
NBPME Part II		
NBPME Part III		

Request the exam service to send score reports directly to the Board office.

LICENSURE AND PRACTICE HISTORY

10. Have you ever been granted a podiatric or other healthcare license by any U.S. state, territory, or District of Columbia? Yes No If yes, complete the following for all licenses. Use a separate sheet if necessary.

License Type	License Number	Issuing State/Jurisdiction	Effective Dates

Contact each state listed above and request a written license verification to be sent directly to the Delaware Board of Podiatry.

11. Have you ever been *denied* a podiatric or other healthcare license by any U.S. state, territory, or the District of Columbia? Yes No If yes, explain on a separate sheet of paper. Include the license type, the state or territory, and the reason for denial for all licenses.
12. Have you been the recipient of any administrative penalties regarding your practice of podiatry in any jurisdictions such as fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations, or been a party to a "consent agreement" containing conditions placed by a board on your professional conduct and practice including any voluntary surrender of a license?
Yes No
13. Have you ever had a podiatric license revoked, suspended, limited, or placed on probation? Yes No
14. Have you ever had a disciplinary action taken against you by a Podiatric Medical Society? Yes No
15. Has a hospital ever changed your privileges as a result of a disciplinary action? Yes No
16. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor, or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes No If yes, submit a certified copy of your criminal history record.
17. Are any charges pending against you or are you currently under investigation for felony, misdemeanor, unprofessional conduct, professional misconduct, or malpractice? Yes No
18. Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department, the Drug Enforcement Agency of the Department of Justice, or any state's Narcotic Agency in this country or any other country? Yes No

19. Have you ever:

- Engaged in the practice of podiatric medicine without a license? Yes No
- Employed or knowingly cooperated in fraud or material deception to acquire a podiatric license? Yes No
- Impersonated another person holding a podiatric license? Yes No
- Allowed another person to use your podiatric license? Yes No
- Aided or abetted a person not licensed as a podiatrist to represent himself or herself as a podiatrist? Yes No

20. Have you ever been denied a narcotic license or had such license modified, restricted, suspended, canceled, or revoked, or have you ever prescribed narcotic drugs unlawfully? Yes No

21. Have you ever entered into a settlement, or had a verdict rendered against you, in a malpractice action? Yes No

22. Are you now, or within the last three years have you been, dependent upon the use of alcohol, stimulants, or habit-forming drugs or alcohol or been treated or disciplined for their use? Yes No

23. Are you physically or mentally incapable of engaging in the practice of podiatric medicine and surgery according to generally accepted standards, and would you submit to an examination to determine such capability as the Board may deem necessary? Yes No

24. Have you had either a mental or physical illness which interfered with your practice for over a month? Yes No

If you answered "Yes" to any Question 12-24, explain the circumstances and ultimate disposition on a separate sheet. Attach any relevant documentation.

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

If your application is approved by the Board, please allow 4-8 weeks to receive your license.

Applications that are not complete within six months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before discarding an abandoned application.

APPLICANT AFFIDAVIT

COMPLETE THIS SECTION IN THE PRESENCE OF A NOTARY PUBLIC.

I certify that I meet all the requirements for licensure specified in 24 Del. C. §508(a)(1) through (a)(7), except for completion of the residency program required by §508(a)(2). *I further certify that I intend to limit myself solely to practice within the hospital of my residency or the performance of such medical duties outside the hospital that may be assigned to me as part of the residency program.*

APPLICANT SIGNATURE: _____ Date: _____

State of _____, County of _____

Sworn and subscribed before me this _____ day of _____ 2_____.

Notary Public Signature: _____

SEAL

My Commission Expires: _____

RESIDENCY PROGRAM DIRECTOR'S AFFIDAVIT

THE RESIDENCY PROGRAM DIRECTOR FOR THE APPLICANT'S TRAINING INSTITUTION MUST COMPLETE THIS SECTION IN THE PRESENCE OF A NOTARY PUBLIC.

I verify that the above-named applicant will be participating in a training program at:

_____ beginning _____.
Name of Institution Date (mm/dd/yy)

I further verify that his/her credentials have been reviewed and approved. This physician will be participating in this training program under the supervision of a fully licensed podiatric physician in the State of Delaware.

Printed Name of Residency Program Director DE License No.

Signature of Residency Program Director: _____ Date: _____

State of _____, County of _____

Sworn and subscribed before me this _____ day of _____ 2_____.

Signature of Notary Public: _____

SEAL

My Commission Expires: _____

THE PHYSICIAN NAMED BELOW WILL ACCEPT RESPONSIBILITY FOR THE PRACTICE OF MEDICINE AND SURGERY OF THIS APPLICANT IN THIS INSTITUTION.

Printed Name of Supervising Physician DE License No.

Signature of Supervising Physician: _____ Date: _____