NORTH DAKOTA BOARD OF PODIATRIC MEDICINE

RESIDENCY PROGRAM DIRECTOR'S AFFIDAVIT

Name of Applicant for Temporary Permit: _____

Applicant's Start Date (Month/Day/year):_____

Name of Residency Program: _____

Name of Residency Program Director: _____

Residency Program Address: _____

_____

- I verify that the above-named applicant has been accepted and will be participating in the above-named residency program.
- I verify that the applicant will be participating in this training program under the supervision of a fully licensed podiatric physician in the State of North Dakota.
- I further verify that the applicant's credentials have been fully reviewed and approved by the residency program's administration.

Dated this _____ day of _____, 20____.

_____
Signature of Residency Program Director

_____
Printed Name of Residency Program Director

Subscribed and sworn to before me this _____day of _____, 20___.

_____
Notary Public
My commission expires: _____, 20___.

Clear Form Print for Mailing