

NORTH DAKOTA BOARD OF PODIATRIC MEDICINE

APPLICATION FOR TEMPORARY PERMIT

Section 1. Biographical Information – Please answer every question. *The e-mail provided will be used by the board as the primary method of contact during the application process. Please indicate if this is not acceptable.*

Name: (Last, First, Middle)

Previous or Former Name:

Current/Permanent Address:

Date of Birth: _____

Place of Birth: _____

Current/Permanent Phone: _____

Gender: _____

Address during Residency:

Social Security #: _____

DEA Registration #: _____

(If applicable)

Phone during Residency:

Cell Phone: _____

E-mail Address: _____

Date of Commencement of Residency:

Section 2. Education and Training.

A. Podiatric Medical School

Name: _____

Address: _____

Date of Entrance: _____ Date of Graduation: _____

B. National Board of Podiatric Medical Examiners Examination:

Part I: Date Completed: _____ Score: _____

Part II: Date Completed: _____ Score: _____

Part III (PMLexis): Date Completed: _____ Score: _____

(If applicable)

Section 3. Professional Practice and Licensure.

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

State	License No.	Dates held	Current Status

B. Date, disposition and number of malpractice award(s) or settlement(s) relating to podiatric medical treatment in the past five years. (If none, please indicate “none”.)

Disposition	Date of Disposition

Section 4. Conduct and Ability to Practice. (If the answer to any question below is ‘yes’, please explain in the space provided or attach additional documentation, as needed.)

1.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been denied a license to practice podiatric medicine?
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been convicted of a crime, felony or misdemeanor?
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been arrested for, or charged with, any crime? Or, to your knowledge, are you under investigation by any federal, state or local law enforcement authority?
4.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever surrendered a license to practice medicine or allowed a license to practice medicine lapse or expire prior to the conclusion of any investigation or disciplinary proceedings?
6.	<input type="checkbox"/> Yes <input type="checkbox"/> No	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been denied a DEA certificate, or has your DEA certificate ever been restricted, limited, conditioned or surrendered?
8.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had privileges to practice or treat patients in a health care facility denied, removed or restricted, or limitations imposed on such privileges? Or, have you resigned prior to the conclusion of any investigation or disciplinary proceeding?
9.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently responding to or litigating any malpractice insurance claims?
10.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Within the past five years, have you had any physical, mental, or emotional condition which impaired or does impair your ability to practice medicine safely and competently?
11.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Within the past five years, have you been admitted to any hospital or other inpatient care facility for any physical, mental or emotional condition?

12.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have or within the past five years have you had a dependency on the use of alcohol or drugs which impaired or does impair your ability to practice medicine competently?
13.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Within the past five years, have you engaged in the excessive or habitual use of alcohol or drugs or received any treatment for alcoholism or excessive or illegal drug use?

Section 5. Documentation required.

In support of this application, the applicant must provide or arrange for the production of the following data. Additional data may be required by the board as deemed necessary to process the application and to protect the health, safety, and welfare of the citizens of North Dakota.

1. This application, completed in full, signed and notarized.
2. Unmounted recent photograph of applicant approximately 3 x 4 inches and signed by the applicant in ink on the front of the photograph.
3. **Certified** copy of the diploma from the applicant's college or university of podiatry. (If a **certified** copy of the diploma cannot be provided, then a copy of the applicant's transcripts received directly from the podiatric medical school will be required in addition to a uncertified copy of the diploma.)
4. Residency Program Director's Affidavit (form provided with application).
5. If disciplinary action has been taken against the applicant's license, documentation concerning standing and disposition must be received directly from the licensing board issuing the action.
6. Verification of licensure in all states and countries in which a license is currently held or has been held. (Verifications must be received directly from the licensing board.)
7. Application Fee of \$300.00 (non-refundable).

Section. Certifications.

A. Agreement to Update Application Information.

If any of the information supplied on this application form changes, or becomes inaccurate or incomplete before I am granted a temporary permit to practice podiatry under the supervision of a currently licensed podiatrist in North Dakota, I will immediately provide the corrected information to the North Dakota Board of Podiatric Medicine.

Signature of Applicant

B. Affidavit.

I, _____, being first duly sworn upon my oath, depose and say: that I am the person herein named subscribing to this application; that I have read the statutes and rules regarding licensure; that I have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Podiatric Medicine as prescribed by this application; that the same was procured in the regular course of instruction and

examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware. Further, I hereby authorize all hospitals, institutions or organizations, any references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the North Dakota Board of Podiatric Medicine any information, files or records, including personal medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application, or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of podiatry. I further authorize the North Dakota Board of Podiatric Medicine or its successors to release to the organizations, individuals or groups listed above any information which is material to the application or any subsequent licensure. I hereby release the North Dakota Board of Podiatric Medicine from any liability arising out of the furnishing or inspection of such information. I further acknowledge that falsification or misrepresentation of any item or response on this application constitutes sufficient cause to deny the same or to hold a hearing to revoke the same, if issued.

Signature of Applicant

Subscribed and sworn to before me this _____ day of _____, 20__.

Notary Public

My commission expires: _____, 20__.