NORTH DAKOTA BOARD OF PODIATRIC MEDICINE

APPLICATION FOR LICENSURE

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)

_____

Business Name: _____

Business Address: _____

_____

Business Phone: _____

Home Address: _____

_____

_____

Home Phone: _____

Cell Phone: _____

Intended Podiatric Practice Location in ND:

_____

Anticipated Starting Date:

_____

Previous or Former Name:

_____

Date of Birth: _____

Place of Birth: _____

Gender: _____

SSN: _____

DEA Registration #: _____

E-mail Address:

_____

List each state of residence since your 18th birthday and the approximate dates of residence:

_____

_____

_____

_____

Section 1A. Military Information.

Are you active military? ☐ Yes ☐ No

Are you the spouse of an individual that is active military? ☐ Yes ☐ No

If the answer to either of the above questions is yes, please attach a copy of current military orders.

Section 2. Education and Training.

A. Podiatric Medical School

Name: _____

Address: _____

Date of Entrance: _____ Date of Graduation: _____

B. Internship/Residency Training in Podiatric Medicine

Name of Facility or Sponsoring Institution: _____

Address: _____

Dates of Training: From _____ to _____

C. American Podiatric Medical Licensing Examination (f.k.a. National Board of Podiatric Medical Examiners Examination):

Part I: Date Completed: _____ Score: _____

Part II: Date Completed: _____ Score: _____

Part II CSPE: Date Completed: _____ Score: _____

Part III: Date Completed: _____ Score: _____

Section 3. Professional Practice and Licensure.

A. List the name, address, dates of practice or employment, reason for departure, of all locations in which you provided podiatric medical services, including clinic, hospital and office locations (attach another sheet if necessary).

Name & Address of Facility	Start Date	End Date	Reason for Departure

B. List all states, jurisdictions and countries in which you have held a podiatric medicine license or permit. Attach separate sheet, if needed.

State/Country	License Number	Issue Date	Expiration Date	Current Status

C. For applicants licensed in another state, provide the following information for the past five years. Attach separate sheet, if needed.

Name and Address of Professional Liability Insurer	Policy Dates (i.e. From: mo/yr To: mo/yr)

D. 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**".)* Attach separate sheet, if needed.

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.	☐Yes ☐No	Have you ever been denied a license to practice podiatric medicine?
2.	☐Yes ☐No	Have you ever been convicted of a crime, felony or misdemeanor?
3.	☐Yes ☐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.	☐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 medicine or allowed a license to practice medicine lapse or expire prior to the conclusion of any investigation or disciplinary proceedings?

6.	☐ Yes ☐ 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.	☐ Yes ☐ No	Have you ever resigned, been terminated or released from employment while employed in a private practice, clinic or hospital, or any other medical service entity?
8.	☐ Yes ☐ No	Have you ever been denied a DEA certificate, or has your DEA certificate ever been restricted, limited, conditioned or surrendered?
9.	☐ Yes ☐ 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?
10.	☐ Yes ☐ No	Are you currently responding to or litigating any malpractice insurance claims?
11.	☐ Yes ☐ 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?
12.	☐ Yes ☐ 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?
13.	☐ Yes ☐ 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?
14.	☐ Yes ☐ 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. Personal References. Please provide the name of three references who have known you personally for at least one year or more, are willing to attest to your ethical and moral character, and are willing to furnish a letter to the ND Board of Podiatric Medicine. No more than two references may be teachers or doctors of podiatry. No relative references will be accepted.

Reference No. 1.

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____

Reference No. 2.

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____

Reference No. 3. Name: _____

Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____

Section 6. 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 and duly executed.
2. Unmounted recent photograph of applicant approximately 3 x 4 inches and signed on face in ink with the applicant's signature.
3. Certified copy of the diploma from the applicant's college or university of podiatry.
4. Verification of successful completion of a clinical residency received directly from the clinical residency program or preceptorship.
5. Transcripts from college or university of podiatry received directly from the school.
6. Certified copy of applicant's national board examination scores, all parts.
7. Three (3) letters of reference. (No more than two from teachers and doctors of podiatry. No references from relatives will be accepted.)
8. 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.
9. 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.)
10. Name and address of applicant's professional liability insurance carrier as well as documentation regarding disposition of any malpractice claims.
11. Application Fee of $300.00 (non-refundable).
12. Photocopy of Military Identification and current military orders (if applicable).

Section 7. Personal Appearance/Oral Practical Examination

All applicants are required to make a personal appearance before the board before full licensure is issued.
Once the application file is complete, a temporary license may be issued to the applicant until such time as the board's next regularly scheduled board meeting where the applicant may make his personal appearance and be interviewed by the board.

In addition, some applicants may be required to appear before the board for oral-practical examination. The board office will notify the applicant if this examination is deemed required and will schedule the examination.

Section 8. 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 license to practice podiatric medicine in North Dakota, I will immediately provide the corrected information to the North Dakota Board of Podiatric Medicine.

_____
Signature of Applicant

Date: _____

B. Affidavit.

I, _____, state that the following is true and correct under the penalty of perjury.

I am the person named in this application; that I have read the statutes and rules regarding licensure; that I have read the complete application, know the full content of it, and declare that all of the information contained in it and the evidence or other credentials submitted with it are true and correct.

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 licensure or to hold a hearing to revoke licensure, if previously issued.

_____
Signature of Applicant

Date: _____

County of _____ State of _____

Print for Mailing