# STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

4201 Patterson Ave • Baltimore, MD 21215-2299 • Phone: 410-764-4785 • Fax: 410-358-3083

### APPLICATION FOR A LIMITED LICENSE

#### REQUIRED FORMS AND DOCUMENTS: PRIMARY SOURCE DOCUMENTATION REQUIRED

Item	Description	For Board Use Only
1.	Application_with recent passport quality in color photograph attached to upper right hand corner. Application signature must be notarized.	
2.	NON-REFUNDABLE Application Fee of \$100 Check payable to: State Board of Podiatric Medical Examiners	
3.	Podiatry College Transcript - Official Copy	
4.	National Board Scores Both Parts. Only official reports bearing the seal of the National Board of Podiatric Medical Examiners are acceptable. Order Reports at: www.fpmb.org	
5.	Notarized Residency Affidavit	
6.	State Licensure Affidavit(s) Applicants that hold or have ever held a license in another state including Limited/Temporary licensure.	1.     2.       3.     4.
7.	Copy of your Letter of Appointment	
8.	For Rotations Only: Copy of Affiliation Agreement	
9.	Jurisprudence Online Lecture Affidavit	
	<u>Jurisprudence Exam Affidavit</u>	
	<u>Jurisprudence Exam</u>	

PRIMARY SOURCE VERIFICATION: Defined as verification by the <u>original source</u> of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Verification documents must be <u>sent to the Board directly from the ORIGINAL SOURCE</u>. Verification documents forwarded to the Board from the applicant <u>are not</u> accepted.

### **BOARD USE ONLY**

Date	
	Signature
Date	
	Signature
License Issue	
Date	Signature
	Date License Issue

### STATE OF MARYLAND BOARD OF PODIATRIC MEDICAL EXAMINERS APPLICATION FOR A LIMITED LICENSE

Last Name	First Name	Middle	
Present Address			
City	State	Zip code	
Phone Number	Ema	Email Address	
Permanent Address			
City	State	Zip code	
Phone Number			
Date of Birth	Place	Place of Birth	
Social Security Number: ———			
	state residency program that requires reasted ase enter Maryland Hospital & Rotation		
RESIDENCY PROGRAM			
Name of Facility:			
Address:			
	e before another State Board at this tim		
f yes, give details:			
lave you ever been refused ex	amination by a State Board? YES	□ NO □	
f yes, give name of Board and	details:		
Have you ever been convicted of	of a crime? YES NO NO		

If yes, give details:	
Have you ever been addicted to, or treatifyes, give details:	ated for addiction to drugs or alcohol? YES NO
List state(s) which you have been lice	ensed to practice podiatry. Please note that a Licensure the Licensing Board for each state listed.
State: License Number Date of original issuance: Expiration Date:	State: License Number Date of original issuance: Expiration Date:
Has your license to practice in any State YES NO If yes, give details:	e ever been subject of an investigation and/or disciplinary action?
List any previous postgraduate clinic years of practice:	cal training or / and, If you have practiced, list locations and
Examiners, and that the statements her comply with all requirements of the laws pledge that I shall abstain from all dece	being duly sworn do hereby swear for licensure before the Maryland Board of Podiatric Medical rein contained are true in every respect. If granted licensure, I will se governing the practices of podiatry in the State of Maryland, and ptive and fraudulent methods of practice, immoral, unethical temp tractice in accordance with the Code of Ethics adopted by the
Signature of applicant	Date
Subscribed and sworn before me this	day of
NOTARY PUBLIC	
My commission expires	SEAL AND STAMP



# STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

4201 Patterson Ave •Baltimore, MD 21215-2299 •Phone: 410-764-4785 •Fax: 410-358-3083

### STATE LICENSURE AFFIDAVIT

THIS PORTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO LICENSING BOARD(S) IN THE STATE(S) WHERE LICENSED.

Last	First	Middle	
Date of Birth		Social Security Number	
State Board	Podiatry Co	Podiatry College & Date of Graduation	
THIS PORTION TO BE COMPLETED BY ST	ATE LICENSING BOARD		
License Number	Date of Original Issue	9	
Is License in Good Standing?	Expiration Date of Lic	Expiration Date of License	
License Type: Full/Unrestricted Te	emporary/Limited Other, plo	ease specify:	
Licensed by: State Examination v	vithout Examination	Please specify:	
Is the applicant currently the subject of a pen- state? YES NO	ding investigation by a licensing of the light of the lig		
Have formal disciplinary proceedings been in state? YES NO	itiated against applicant's license If "yes", please attach docun		
Has the applicant ever been warned, censure revoked, suspended, or in any other manner YES NO If "yes",			
Form Completed by:	1	- Fitle	
Signature	]	Date	
State Board		PLEASE AFFIX BOARD SEAL	

(not valid without board seal)



# STATEBOARDOFPODIATRIC MEDICAL EXAMINERS

4201 Patterson Ave •Baltimore, MD 21215-2299 •Phone: 410-764-4785 •Fax: 410-358-3083

### **RESIDENCY AFFIDAVIT**

THIS PORTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO THE RESIDENCY PROGRAM (S) ATTENDED

Last Name	First	Middle
ate of Birth Social Security Number		
Facility Name/Dates of Attendance	<del></del>	
Facility Address		
THISPORTIONTOBE	COMPLETEDBYTHERES	IDENCYPROGRAM DIRECTOR
This is to certify that the above	named applicant:	
is currently attending and has postgraduate clinical training	now successfully completed_ in the program listed above wi	years of thickness of the state
has successfully completed tabove on	hree years of postgraduate cli	nical training in the program listed
has only completed	years before leaving the pr	ogramondue to reason:
Explanation Required		
Name & Title of Program Director	Of	fice Telephone
Signature of Program Director	Da	ate
Printed full name of Notary	Co	ommission Expiration Date
Signature of Notary		NOTARY SEAL & STAMP (Not valid without seal)