

STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

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

APPLICATION FOR A FULL LICENSE

REQUIRED FORMS AND DOCUMENTS: PRIMARY SOURCE DOCUMENTATION REQUIRED

Item	Description	BOARD USE ONLY	
1.	<u>APPLICATION</u> with recent passport sized photograph attached to upper right hand corner, with your notarized signature .		
2.	FEES NONREFUNDABLE Application Fee of \$50.00 <u>plus</u> \$1050.00 January Licensure (<i>issued January 1 – June 30</i>) \$850.00 July Licensure (<i>issued July 1 – December 31</i>) Check payable to: Board of Podiatric Medical Examiners		
3.	<u>PODIATRY COLLEGE TRANSCRIPT</u> - Official Copy		
4.	<u>NATIONAL BOARD SCORES BOTH PARTS</u> . Only official reports bearing the seal of the National Board of Podiatric Medical Examiners are acceptable. <i>Order Reports at 1-877-302-8952</i>		
5.	<u>PM LEXIS EXAMINATION SCORES</u> Only certified reports from the Federation of Podiatric Medical Boards are acceptable. <i>Order Reports at http://www.fpmb.org</i>		
6.	<u>NOTARIZED RESIDENCY AFFIDAVIT</u> <i>or</i> Certification of 5 years practice, whichever is applicable.		
7.	<u>STATE LICENSURE AFFIDAVIT(S)</u> Applicants that hold or have ever held a license in another state including Limited/Temporary licensure.	1.	2.
		3.	4.
8.	<u>DISCIPLINARY REPORT</u> by the Federation of Podiatric Medical Boards (Applicable to any applicant licensed in another state). <i>Order Disciplinary Reports at http://www.fpmb.org</i>		
9.	<u>TWO (2) REFERENCE LETTERS</u> from podiatrists addressed to the Board One (1) of which must be from a podiatrist licensed in the state you are currently licensed and practicing.	1.	
		2.	
10.	<u>CURRENT CARDIO PULMONARY RESUSCITATION (CPR) CERTIFICATION</u> (Basic Life Support for Healthcare Professionals)		
11.	<u>JURISPRUDENCE ONLINE LECTURE AFFIDAVIT</u>		
	<u>JURISPRUDENCE EXAM AFFIDAVIT</u>		
	<u>JURISPRUDENCE EXAM</u>		

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

BOARD USE ONLY

Jurisprudence Exam and Law Books Mailed	Date	Signature
NPDB-HIPDB Query	Date	Signature
Approval of License	Date	Signature

**STATE OF MARYLAND
BOARD OF PODIATRIC MEDICAL EXAMINERS
APPLICATION FOR A FULL LICENSE**

Please Type or Print

Last Name	First Name	Middle Initial	Maiden Name
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Present Address

City	State	Zip code
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Phone Number	Cell Number	Email Address
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Permanent Address

City	State	Zip code
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Phone Number

Date of Birth	Place of Birth	Gender (M/F)
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Social Security Number

Note: Your social security number will be used for identification purposes and will be released to the Department of Public Safety and Correctional Services to check for any criminal convictions.

Enter Name of Podiatry College Attended and Graduation Date Below:

Select one or more of the following racial categories:

1. American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
2. Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
3. Black or African American (A person having origins in any of the black racial groups of Africa.)
4. Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
5. White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)
6. Other

Please respond to whichever of the following is applicable:

A. **POST GRADUATE CLINICAL TRAINING.** *(List all residency program attended; continue on separate page if required)*

Identify each Residency Program

I)

Name of Facility

Address

Dates of Post Graduate Training

II)

Name of Facility

Address

Dates of Post Graduate Training

B. **PRACTICE REQUIREMENT.** List location(s) and dates of practice.

Note: All applicants must have either completed one year of post graduate training in a residency program or have a least (5) years in active clinical practice preceding application to be eligible for licensure in Maryland.

List state(s) in which you are licensed or have ever been licensed to practice Podiatry. Please note that each Licensing Board for the state listed must complete a Licensure Affidavit form.

State: _____
License Number _____
Date of original issuance: _____
Expiration Date: _____

State: _____
License Number _____
Date of original issuance: _____
Expiration Date: _____

State: _____
License Number _____
Date of original issuance: _____
Expiration Date: _____

State: _____
License Number _____
Date of original issuance: _____
Expiration Date: _____

Continue on separate page if required

Is your application for licensure before another State Board at this time? YES NO

If yes, give details: _____

Have you ever been refused examination by a State Board? YES NO

If yes, give name of Board and details: _____

Has your license to practice in any State ever been subject of an investigation and/or disciplinary action? YES NO

If yes, give details: _____

Have you ever been convicted of a crime? YES NO

If yes, give details: _____

Have you ever been addicted to, or treated for addiction to drugs or alcohol? YES NO

If yes, give details: _____

Has a malpractice suit been filed against you or has a claim for damages been settled or awarded against you? YES NO

If yes, give details: _____

****[Reference Letters Requirements for New Applicants Only and not for Reinstatements]****

Please list two (2) podiatrists who will be providing a reference on your behalf as to character, reputation and proof of practice. Request them to send their letters **directly** to the Board.

Name: _____

Address: _____

Name: _____

Address: _____

AFFIDAVIT

I, _____ being duly sworn do hereby swear that I am the person in this application for licensure before the Maryland Board of Podiatric Medical Examiners, and that the statements herein contained are true in every respect. If granted licensure, I will comply with all requirements of the laws governing the practices of podiatry in the State of Maryland, and pledge that I shall abstain from all deceptive and fraudulent methods of practice, immoral, unethical unprofessional conduct and will conduct my practice in accordance with the Code of Ethics adopted by the profession.

Signature of applicant Date

Subscribed and sworn before me this _____ day of _____

NOTARY PUBLIC

My commission expires _____

SEAL
AND
STAMP

Forward completed application to:

**Board of Podiatric Medical Examiners
4201 Patterson Avenue, Room 310
Baltimore, Maryland 21215-2299**



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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 College & Date of Graduation	

THIS PORTION TO BE COMPLETED BY STATE LICENSING BOARD

License Number _____ Date of Original Issue _____

Is License in Good Standing? _____ Expiration Date of License _____

License Type: Full/Unrestricted Temporary/Limited Other, please specify: _____

Licensed by: State Examination without Examination Other, please specify: _____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES NO **If "yes", please attach documentation**

Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? YES NO **If "yes", please attach documentation**

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state? YES NO **If "yes", please attach documentation**

_____	_____
Form Completed by:	Title
_____	_____
Signature	Date

_____ State Board

PLEASE AFFIX BOARD SEAL
(not valid without board seal)

