

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 sized photograph attached to upper right hand corner, with your notarized signature .		
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. <i>Order Reports at 1-877-302-8952</i>		
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		
	Jurisprudence Exam Affidavit		
	Jurisprudence Exam		

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
Approval of License	Date	Signature
License No.	License Issue Date	Signature
Comments		

2 If yes, give details: _____

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

If yes, give details: _____

List state(s) which you have been licensed to practice podiatry. Please note that a Licensure Affidavit form must be completed by 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 ever been subject of an investigation and/or disciplinary action?

YES NO If yes, give details: _____

List any previous postgraduate clinical training or / and, If you have practiced, list locations and years of practice:

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



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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)



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RESIDENCY AFFIDAVIT

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

Last First Middle

Date of Birth Social Security Number

Name of Facility

Address

Dates of Attendance

THIS PORTION TO BE COMPLETED BY THE RESIDENCY PROGRAM DIRECTOR

This is to certify that the above named applicant:

- is currently attending and has now successfully completed _____ years of postgraduate clinical training in the program listed above. **OR**
- has successfully completed postgraduate clinical training in the program listed above.

ADDITIONAL COMMENTS:

Name & Title of Program Director

Signature of Program Director Date

(_____) _____
Office Telephone

NOTARY SEAL & STAMP
(Not valid without seal)