LICENSE INFORMATION FOR A CERTIFICATE TO PRACTICE PODIATRIC MEDICINE

MINIMUM REQUIREMENTS TO APPLY FOR A LICENSE

- To be eligible for licensure in the state of California as a Doctor of Podiatric Medicine, applicants must have graduated from an approved college or school of podiatric medicine approved by the Podiatric Medical Board of California (PMBC).

- Section 31(e) of the Business and Professions Code allows the State Board of Equalization and the Franchise Tax Board to share taxpayer information with the Board. A license issued by the Board may be suspended if state tax obligation is not paid. Disclosure of your United States Social Security Number or Individual Taxpayer Identification Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405 (c)(2)(c)) authorize collection of your social security number. *Reporting a number on your Application that is not your U.S. Social Security Number of Individual Taxpayer Identification Number may be grounds for denial of licensure.*

GENERAL INFORMATION

- As an applicant, you personally are responsible for all information disclosed on your Application, Forms P1A – P1GB, including any responses that may have been completed on your behalf by others. An application may be denied based upon omissions, falsification or misrepresentation of any item or response on the application or any attachment. The Podiatric Medical Board of California considers violations of an ethical nature to be a serious breach of professional conduct.

- *Current CA Residents:* If you are a current 3rd year CA resident wishing to apply for a permanent license, please contact the Board at 916-263-2647 for a list of missing requirements. In most cases, documents submitted for a resident license can be used towards permanent licensure requirements.

- *Processing Times:* Application materials are processed in the date order in which the application is received in our office. All application forms and supporting materials are stamped with the date and time received. Generally, you should anticipate receiving written correspondence confirming status of the application for licensure within 15 days of submission of the application.

- *Fingerprints:* Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. You will need to use the *Request for Live Scan Service* form included in this Application packet or on our website. Please refer to the following website for a listing of Live Scan facilities in California: http://ag.ca.gov/fingerprints/publications/contact.php.

  Applicants residing outside California must submit two completed fingerprint cards or have your fingerprints completed at a California Live Scan facility. If fingerprint cards are needed, please call our office at (916) 263-2647 and they will be mailed to you. All personal data must be completed on the fingerprint cards.

If you have ever been convicted of a misdemeanor or felony, the record of the conviction will be reported to the Board as a result of your fingerprint inquiry. *Criminal Records Check from both the California Department of Justice and the Federal Bureau of Investigation must be received prior to the issuance of a Doctor of Podiatric Medicine License.*

- *Convictions:* You are not required to disclose any information or documentation about your criminal history. However, you may choose to provide mitigating information about your criminal history for purposes of determining whether the crime/crimes is/are substantially related to qualifications, functions, or duties of podiatric medicine or to demonstrate evidence of your rehabilitation. Any disclosure about criminal history or mitigating information is VOLUNTARY. Your decision not to disclose this information shall not be a factor in the Board's decision to grant or deny an application for licensure. If you would like to voluntarily provide the Board with mitigating information, you may do so by attaching the information to your application.

- *Grounds for Denial:* Each applicant's credential for podiatric licensure in California are reviewed on an individual basis. The Board has the authority to deny licensure based upon an applicant's act(s) of dishonesty, unprofessional conduct, professional misconduct, conviction of a crime, discipline of another state license, or inability to practice medicine safely.

Listed below are the application and supporting material requirements for licensure as a California Doctor of Podiatric Medicine. This list is not all-inclusive as additional information may be necessary based on responses provided on your Application or information obtained from other entities. Please refer to the *License Application Checklist* and our website for further detailed information regarding each requirement.

☐	Application for Doctor of Podiatric Medicine (Form P1A-P1GB) Complete, certify and submit with a photograph.
☐	Background clearance Copy of Live Scan Request form (CA resident) **or** Two Fingerprint Cards (outside CA).
☐	Application fees of $149 This includes fees for application processing and background clearance. Please make check or money orders payable to the *Podiatric Medical Board of California*. To apply online and pay via credit please visit: www.breeze.ca.gov
☐	Official Pre-Professional Postsecondary Education transcripts (from all colleges or universities attended) An original official school transcript, prepared on university letterhead affixed with the signature of the dean or registrar and the school seal is required. A transcript is required from each school of attendance. ***Transcript(s) must be mailed directly from the school to the Board to be acceptable.***
☐	Official Podiatric Medical Education transcripts (Form P2) An original official medical school transcript, prepared on university letterhead affixed with the signature of the dean or registrar and the medical school seal, documenting all of the basic science and clinical courses completed during the medical curriculum is required. A transcript is required from each school of attendance. ***Transcript(s) must be mailed directly from the school to the Board to be acceptable.***

☐	License Verification/Letter of Good Standing by State Licensing Agency (if applicable) (Form P3) Forward this form to licensing agencies by any state or country in which you have held a medical license, including temporary or limited/resident licenses. ***Verification must be completed and mailed directly from the licensing agency to the Board to be acceptable.***
☐	Certificate of Approved Residency Training (Form P4A – P4B) Forward this form to your Residency Director for completion and return directly to the Board. In lieu of this form, your Residency Director may prepare a letter on official letterhead with original signature, verifying completion of the program. ***Certification must be completed by each residency program and mailed directly from the residency program to the Board to be acceptable.***
☐	Official American Podiatric Medical Licensing Examination (APMLE) Parts I, II & III (PMLexis) Scores Parts I, II & II CSPE – resident license; Parts I, II, II CSPE & III for permanent license ***Each score report must be an original, official score report received directly from FPMB to the Board to be acceptable.***
☐	Memorandum of Understanding for Approved Residency Program Participation **or** Memorandum of Understanding for "Candidate Status" Residency Program Participation (Form P5A or P5B) Complete and send in with your application acknowledging your participation a residency program.
☐	Disciplinary Databank Report Request this report directly from the Federation of Podiatric Medical Boards (FPMB) website at www.fpmb.org. ***This report must be received directly from FPMB to the Board to be acceptable.***
☐	Explanation to Question # ____ (if applicable) The *Explanation to Questions* # ____ form may be used to provide a detailed written explanation for a "yes" response to a question on the application. The Board will also accept a signed and dated letter of explanation.
☐	Birth Month Licensure Request Complete the *Birth Month Request* form and submit it with your application.
☐	License fees: Resident/Limited License fee $100 Permanent License $900 This fee is payable upon meeting all licensure requirements or at any point during the application process. Please make check or money orders payable to the *Podiatric Medical Board of California*. To apply online and pay via credit card please visit: www.breeze.ca.gov

PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA dca DEPARTMENT OF CONSUMER AFFAIRS

LICENSE APPLICATION CHECKLIST FOR A CERTIFICATE TO PRACTICE PODIATRIC MEDICINE

(Do Not Submit – Keep for your records)

Application, Fees and Fingerprints			
☐	Application Fee	A minimum of $149 is required to submit an application for licensure. This includes fees for application processing and background clearance. Please make check or money orders payable to the *Podiatric Medical Board of California*. To apply online and pay via credit card please visit: www.breeze.ca.gov	Notes/Date Sent:
☐	Application (P1A-P1GB) ☐ P1A ☐ P1B ☐ P1C ☐ P1D ☐ P1E ☐ P1F ☐ P1G	Complete all fields and answer all questions.	Notes/Date Sent:
☐	Fingerprints: Live Scan Request Form OR Two Fingerprint Cards	Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. A copy of the *Request for Live Scan* form must be submitted with your application. Applicants residing outside California may submit two completed fingerprint cards or visit a California Live Scan facility. If fingerprint cards are needed, please call our office at (916) 263-2647 and they will be mailed to you. <u>All personal data must be completed on the fingerprint cards</u>.	Notes/Date Sent:
☐	Official Pre-professional Postsecondary Education transcripts	All official school transcript(s) required from each college or university attended. ***Transcript(s) must be mailed directly from the school to the Board to be acceptable.***	Notes/Date Sent:
☐	Official Podiatric Medical School (Form P2)	An official podiatric medical school transcript is required from each podiatric medical school attended. ***Transcript(s) must be mailed directly from the school to the Board to be acceptable.***	Notes/Date Sent:
☐	License Verification/Letter of Good Standing by State Licensing Agency (if applicable) (Form P3)	This form is to be completed by each licensing agency by any state or country in which you have held a medical license, including temporary or limited/resident licenses. ***Verification must be completed and mailed directly from the licensing agency to the Board to be acceptable.***	Notes/Date Sent:

☐	Certificate of Approved Residency Program Training (Form P4)	Forward this form to your Residency Director for completion and return directly to the Board. In lieu of this form, your Residency Director may prepare a letter on official letterhead with original signature, verifying completion of the program. ***Certification must be completed and mailed directly from the residency program to the Board to be acceptable.***	Notes/Date Sent:
☐	Official American Podiatric Medical Licensing Examination (APMLE) and Part III (PMLexis) reports: ☐ Parts I, II & II CSPE ☐ Part III **(Permanent License Only)**	Official board score reports may be requested from the following websites: FPMB: www.fpmb.org ***Each score report must be an original, official score report received directly from the FPMB to the Board to be acceptable.***	Notes/Date Sent:
☐	Memorandum of Understanding (MOU) for: ☐ Approved Residency Program Participation (Form P5A) ☐ "Candidate Status" Residency Program Participation (Form P5B)	Complete all fields, sign and date. MOU for Approved Residency Program Participation means that your residency program has been approved by the Council on Podiatric Medical Education (CPME). MOU for "Candidate Status" Residency Program Participation means that your residency program has **not** been approved by the CPME. View the List of Approved Residencies on CPME's website to determine eligibility: www.cpme.org.	Notes/Date Sent:
☐	Disciplinary Databank Report **(Permanent License Only)**	Request this report directly from the Federation of Podiatric Medical Boards (FPMB) website at www.fpmb.org. ***This report must be received directly from the FPMB to the Board to be acceptable.***	Notes/Date Sent:
☐	Explanation to Question # ____ (if applicable)	The *Explanation to Questions* # ____ form may be used to provide a detailed written explanation for a "yes" response to a question on the application. The Board will also accept a signed and dated letter of explanation.	Notes/Date Sent:
☐	License Expiration Advisory and Request for Birth Month Licensure	Complete the *License Expiration Advisory and Request for Birth Month* form and submit it with your application.	Notes/Date Sent:
☐	License fees: ☐ Resident License $100 ☐ Permanent License $900	A license fee is payable upon meeting all licensure requirements or at any point during the application process. Please make check or money orders payable to the *Podiatric Medical Board of California*. To apply online and pay via credit card please visit: www.breeze.ca.gov	Notes/Date Sent:

PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

LIVE SCAN INFORMATION

CALIFORNIA DOES NOT HAVE LIVE SCAN LINKS TO ANY OTHER STATES.

The *Request for Live Scan* form is required to have your fingerprints processed by Live Scan. This form must be completed in triplicate; therefore, THREE copies will be printed automatically when printing this form. Please ensure that all personal data is provided on *each of the three forms.* The last section of the form requires information form the fingerprint agency; please ensure this information is completed or the forms will be void. **It is the responsibility of the applicant to ensure that the person scanning the fingerprints submits TWO digital prints, one for the DOJ and one for the FBI.**

Applicants can access the website, https://oag.ca.gov/fingerprints/locations to obtain the names and location of approved fingerprint sites. After completing the Live Scan process, applicants must submit ONE of the three forms with the initial application to document the scanning of their fingerprints. The results of Live Scan fingerprints are generally received within five (5) days. The results of paper fingerprint cards are generally received within twelve (12) weeks.

Whether you use Live Scan or paper fingerprint cards, you will be charged an administrative fee by the local agency that scans the prints or provides the inked impression. This is in addition to the fingerprint processing fee that must be paid to the Podiatric Medical Board with your application. For information about the fingerprint clearance process and time frames, you may access https://oag.ca.gov/fingerprints.

Because applicants from medical profession must be concerned with sanitary issues, they wash and scrub their hands so much that images of their fingerprints are often difficult to read. When the impressions are of such poor quality that they cannot be searched in DOJ's or FBI's fingerprint data base, the fingerprints (whether Live Scan or paper cards) are rejected and reprints will be necessary. Therefore, please advise the person processing your fingerprints that extra care needs to be given to ensure that clear impressions have been made.

FINGERPRINT CLEARANCES FROM BOTH THE DOJ AND THE FBI MUST BE RECEIVED PRIOR TO THE ISSUANCE OF A DOCTOR OF PODIATRIC MEDICINE LICENSE IN CALIFORNIA

If you have ever been convicted of a misdemeanor or felony, the record of conviction will be reported to the Board as a result of your fingerprint inquiry.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A0434
ORI (Code assigned by DOJ)

LICENSE, CERTIFICATION, PERMIT
Authorized Applicant Type

DOCTOR OF PODIATRIC MEDICINE
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

PODIATRIC MEDICAL BOARD OF CALIFORNIA
Agency Authorized to Receive Criminal Record Information

03802
Mail Code (five-digit code assigned by DOJ)

2005 EVERGREEN STREET, SUITE 1300
Street Address or P.O. Box

ANDREIA DAMIAN
Contact Name (mandatory for all school submissions)

SACRAMENTO
City

CA
State

95815
ZIP Code

(916) 263-2649
Contact Telephone Number

Applicant Information:

Last Name

First Name | Middle Initial | Suffix

Other Name: (AKA or Alias)

Last Name

First Name | Suffix

Date of Birth

Sex Male Female

Driver's License Number

Height | Weight | Eye Color | Hair Color

Billing Number BIL - 100026
(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number
(Other Identification Number)

Home Address
Street Address or P.O. Box

City | State | ZIP Code

I have received and read the included Privacy Notice, Privacy Act Statement, and Applicant's Privacy Rights.

Applicant Signature

Date

Your Number:
OCA Number (Agency Identifying Number)

Level of Service: DOJ FBI
(If the Level of Service indicates FBI, the fingerprints will be used to check the criminal history record information of the FBI.)

If re-submission, list original ATI number:
(Must provide proof of rejection)
Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Street Address or P.O. Box

Telephone Number (optional)

City | State | ZIP Code

Mail Code (five digit code assigned by DOJ)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency | LSID | ATI Number | Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A0434
ORI (Code assigned by DOJ)

LICENSE, CERTIFICATION, PERMIT
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Contact Telephone Number

Applicant Information:

Last Name

First Name | Middle Initial | Suffix

Other Name: (AKA or Alias)

Last Name

First Name | Suffix

Date of Birth

Sex Male Female

Driver's License Number

Height | Weight | Eye Color | Hair Color

Billing Number BIL - 100026
(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

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(Must provide proof of rejection)
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Authorized Applicant Type

DOCTOR OF PODIATRIC MEDICINE
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

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Contact Name (mandatory for all school submissions)

SACRAMENTO
City

CA
State

95815
ZIP Code

(916) 263-2649
Contact Telephone Number

Applicant Information:

Last Name

First Name | Middle Initial | Suffix

Other Name: (AKA or Alias)

Last Name

First Name | Suffix

Date of Birth

Sex Male Female

Driver's License Number

Height | Weight | Eye Color | Hair Color

Billing Number BIL - 100026
(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number
(Other Identification Number)

Home Address
Street Address or P.O. Box

City | State | ZIP Code

I have received and read the included Privacy Notice, Privacy Act Statement, and Applicant's Privacy Rights.

Applicant Signature

Date

Your Number:
OCA Number (Agency Identifying Number)

Level of Service: DOJ FBI
(If the Level of Service indicates FBI, the fingerprints will be used to check the criminal history record information of the FBI.)

If re-submission, list original ATI number:
(Must provide proof of rejection)
Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Street Address or P.O. Box

Telephone Number (optional)

City | State | ZIP Code

Mail Code (five digit code assigned by DOJ)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency | LSID | ATI Number | Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Privacy Notice

As Required by Civil Code § 1798.17

Collection and Use of Personal Information. The California Justice Information Services (CJIS) Division in the Department of Justice (DOJ) collects the information requested on this form as authorized by Business and Professions Code sections 4600-4621, 7574-7574.16, 26050-26059, 11340-11346, and 22440-22449; Penal Code sections 11100-11112, and 11077.1; Health and Safety Code sections 1522, 1416.20-1416.50, 1569.10-1569.24, 1596.80-1596.879, 1725-1742, and 18050-18055; Family Code sections 8700-87200, 8800-8823, and 8900-8925; Financial Code sections 1300-1301, 22100-22112, 17200-17215, and 28122-28124; Education Code sections 44330-44355; Welfare and Institutions Code sections 9710-9719.5, 14043-14045, 4684-4689.8, and 16500-16523.1; and other various state statutes and regulations. The CJIS Division uses this information to process requests of authorized entities that want to obtain information as to the existence and content of a record of state or federal convictions to help determine suitability for employment, or volunteer work with children, elderly, or disabled; or for adoption or purposes of a license, certification, or permit. In addition, any personal information collected by state agencies is subject to the limitations in the Information Practices Act and state policy. The DOJ's general privacy policy is available at **http://oag.ca.gov/privacy-policy**.

Providing Personal Information. All the personal information requested in the form must be provided. Failure to provide all the necessary information will result in delays and/or the rejection of your request.

Access to Your Information. You may review the records maintained by the CJIS Division in the DOJ that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information. In order to process applications pertaining to Live Scan service to help determine the suitability of a person applying for a license, employment, or a volunteer position working with children, the elderly, or the disabled, we may need to share the information you give us with authorized applicant agencies.

The information you provide may also be disclosed in the following circumstances:

- With other persons or agencies where necessary to perform their legal duties, and their use of your information is compatible and complies with state law, such as for investigations or for licensing, certification, or regulatory purposes.
- To another government agency as required by state or federal law.

Contact Information. For questions about this notice or access to your records, you may contact the Associate Governmental Program Analyst at the DOJ's Keeper of Records at (916) 210-3310, by email at **keeperofrecords@doj.ca.gov,** or by mail at:

Department of Justice
Bureau of Criminal Information & Analysis
Keeper of Records
P.O. Box 903417
Sacramento, CA 94203-4170

REQUEST FOR LIVE SCAN SERVICE

Privacy Act Statement

Authority. The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose. Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses. During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental, or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

REQUEST FOR LIVE SCAN SERVICE

Noncriminal Justice Applicant's Privacy Rights

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification[1] that your fingerprints will be used to check the criminal history records of the FBI.
- You must be provided, and acknowledge receipt of, an adequate Privacy Act Statement when you submit your fingerprints and associated personal information. This Privacy Act Statement should explain the authority for collecting your information and how your information will be used, retained, and shared. [2]
- If you have a criminal history record, the officials making a determination of your suitability for the employment, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or update of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the criminal history record. [3]

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. [4]

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at https://www.fbi.gov/services/cjis/identity-history-summary-checks.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.) *You can find additional information on the FBI website at* https://www.fbi.gov/about-us/cjis/background-checks*.*

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[1] Written notification includes electronic notification, but excludes oral notification
[2] https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement
[3] See 28 CFR 50.12(b)
[4] See U.S.C. 552a(b); 28 U.S.C. 534(b); 34 U.S.C. § 40316 (formerly cited as 42 U.S.C. § 14616), Article IV(c)

PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

LICENSE EXPIRATION ADVISORY AND REQUEST FOR BIRTH MONTH LICENSURE

California licensing regulations specify that a license expires at 12 midnight on the last day of the birth month of the licensee during the second year of a two year term. If you are licensed in your birth month, your initial license will be valid for a full 24-month term. If you are licensed in a month other than your birth month, the term of your *initial license* will be less than 24-months.

Please indicate your preference by checking one of the options listed below:

☐	I would like to wait until my birth month of _____ to be licensed.
☐	I would like to be licensed as soon as my application is processed and approved. I understand and acknowledge my *initial license* will be valid for less than a 24-month term.

Printed Name of Applicant: _____

Date of Birth: _____

Signature of Applicant: _____

Date: _____

Please return the form using one of the following methods:

1. Submit the completed form with your initial application.
2. Fax the completed form to the Board at (916) 263.2651.
3. Mail the completed form to the Board at the address listed below.

PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

EXPLANATION TO APPLICATION QUESTION # _____

This form may be used to provide a detailed written explanation for a "yes" response to a question on the Application. Please use as many forms as necessary to provide a detailed explanation. A separate form is to be used for each question.

Please print or type. Illegible applications will be returned.

APPLICANT'S INFORMATION

NAME:

Date of Birth:	**SSN or ITIN:**	**Podiatric Medical School of Graduation:**

NARRATIVE EXPLANATION

SIGNATURE: **DATE:**

Applicant's signature and date are required.

PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

LICENSE APPLICATION FOR A CERTIFICATE TO PRACTICE PODIATRIC MEDICINE

FOR PMBC USE ONLY			
Fee paid:		Receipt #:	
Date Cashiered:		Cashier's Initials:	
Date Approved:		Date Denied:	
Approved Initial:			

Read all instructions prior to completing this application. All questions on this application must be answered, unless otherwise indicated, and all supporting documents must be submitted with this application per instructions.

Please print or type. Illegible applications will be returned.

Limited / Resident License **Permanent License**

PERSONAL INFORMATION			PMBC Use Only
Name:			
Other Name/Alias:			
Social Security Number/Individual Taxpayer Identification Number:	Gender:	Male Female Non-binary	
Date of Birth:			
The address of record is public information and will be displayed on the Podiatric Medical Board's website.			
Address:			
City / State / Zip:			
Telephone Number: Home: Work: Cell:			☐
E-mail Address (optional):			☐
1. Have you ever filed an application for licensure in California that has been withdrawn, abandoned, or denied? *If YES, give date of previous application:*	Yes	No	☐
2. Have you previously held a Doctor of Podiatric Medicine license in California? *If YES, give date and license number:*	Yes	No	☐
			P1A

PERSONAL INFORMATION CONTINUED			PMBC Use Only
3. a. Have you served or are you currently serving in the military?	Yes	No	☐
b. Are you married to, or in a domestic partnership or other legal union with, an active duty member of the U.S. Armed Forces assigned to a duty station in California under official active duty military orders? *If YES, please provide evidence of your marriage, or domestic partnership or other legal union and your spouse or partner's military duty orders.*	Yes	No	☐
c. Are you requesting to expedite this application as the spouse of an active duty member of the U.S. Armed Forces? *If YES, please provide evidence of your marriage, or domestic partnership or other legal union, your spouse or partner's military duty orders and your current DPM licensure in another state, district or U.S. territory.*	Yes	No	☐
d. Are you requesting to expedite this application as an honorably discharged former active duty member of the U.S. Armed Forces? *If YES, please provide evidence of your honorable discharge*	Yes	No	☐
4. Do any of the following statements apply to you:	Yes	No	☐
a. You were admitted to the U.S. as a refugee pursuant to section 1157 of title 8 of the U.S. Code;			
b. You were granted asylum by the Secretary of Homeland Security or the U.S. Attorney General pursuant to section 1158 of title 8 of the U.S. Code; or,	Yes	No	☐
c. You have a special immigrant visa and were granted a status pursuant to section 1244 of Public Law 110-181, Public Law 109-63, or section 602(b) of title VI of division F of Public Law 111-8, relating to Iraqi and Afghan translators/interpreters or those who worked for or on behalf of the U.S. government. *If YES, you must attach evidence of your status as a refugee, asylee, or special immigrant visa holder. Failure to do so may result in application review delays*	Yes	No	☐
5. Are you requesting a temporary license due to being married to, or in a domestic partnership or other legal union with an active-duty member of the U.S. Armed Forces who is assigned a duty station in California under official active-duty military orders?	Yes	No	☐
6. Pursuant to Business and Professions Code Section 115.4, beginning July 1, 2024, the PMBC shall expedite the initial licensure process for an applicant who is an active duty member of the US Armed Forces and enrolled in the US Department of Defense SkillBridge program. Do you request expediting of your application under this authority? *If you select YES, you must attach documentation of enrollment to this application.*	Yes	No	☐

PREMEDICAL EDUCATION

7. List Name and address of all colleges or universities where premedical education was received.

Name of Premedical School(s)	Mailing Address	Attendance Dates		PMBC Use Only
		Start:		☐
		End:		

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PREMEDICAL EDUCATION CONTINUED			PMBC Use Only
Name of Premedical School(s)	Mailing Address	Attendance Dates	
		Start:	☐
		End:	☐
		Start:	☐
		End:	☐

PODIATRIC MEDICAL EDUCATION			
8. List Name and address of all colleges or universities where Podiatric Medical education was received.			
Name of Podiatric School(s)	Mailing Address	Attendance Dates	
		Start:	☐
		End:	☐
		Start:	☐
		End:	☐
School of Graduation	Title of Degree Awarded	Issue Date of Degree	
			☐

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL			
9. Did you ever take a leave of absence during medical school?	Yes	No	☐
10. Were you ever placed on probation during medical school?	Yes	No	☐
11. Were you ever disciplined or placed under investigation during medical school?	Yes	No	☐
12. Were any negative reports ever filed by your instructor?	Yes	No	☐
13. Were any limitations or special requirements imposed on you because of questions of academic or disciplinary problems, or for any other reason during medical school?	Yes	No	☐

EXAMINATIONS			
14. Have you ever been found to have engaged in non-compliant behavior with testing policy during an examination?	Yes	No	☐
15. Have you ever been subject to an investigation by an examination entity?	Yes	No	☐
A "yes" response to questions 9 – 15 requires a signed and dated written explanation.			

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EXAMINATIONS CONTINUED				PMBC Use Only
16. List all the examinations you have taken administered by the National Board of Podiatric Medical Examiners.				
Examination	Location	Date	Result	
Part I				☐
Part II				☐
Part II CSPE				☐
Part III				☐
POSTGRADUATE TRAINING				
17. Have you completed, or are you currently participating in a residency program approved by the Council on Podiatric Medical Education? *If YES, list name and address of the program facility. Submit an original Certificate of Approved Residency Training (Form P4A-P4B). Please use additional sheet of paper if necessary.*		Yes	No	☐
Name of Residency Program and Residency Type	Mailing Address	Attendance Dates		
		Start		☐
		End		☐
Name of Residency Director:				
UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING				
18. Have you ever received partial or no credit for a postgraduate training program?		Yes	No	☐
19. Have you ever taken a leave of absence or break from your training?		Yes	No	☐
20. Have you ever been terminated, dismissed or expelled from a program?		Yes	No	☐
21. Have you ever resigned from a program?		Yes	No	☐
22. Were you ever placed on probation for any reason during post graduate training?		Yes	No	☐
23. Were you ever disciplined or placed under investigation during post graduate training?		Yes	No	☐
24. Were any incident reports ever filed by instructors?		Yes	No	☐
25. Were any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason during post graduate training?		Yes	No	☐
26. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?		Yes	No	☐
A "yes" response to questions 18-26 requires a signed and dated written explanation				**P1D**

PODIATRIC MEDICAL LICENSE					PMBC Use Only
27. Have you ever held, or do you currently hold a podiatric medical license in any other U.S. state or U.S. territory or Canadian province or foreign country? *If YES, list state or country, license number, date issued, and dates of practice in issuing agency's jurisdiction for each license.* ***Submit a Request for License Verification/Letter of Good Standing by State Licensing Agency (Form P3)*** *for a license verification for <u>each</u> state in which you are licensed or have been licensed. Please use additional sheet of paper if necessary.*			Yes	No	☐
State or Country	License Number	Date of Issuance	Dates of Practice		
			Start		☐
			End		
			Start		☐
			End		
			Start		☐
			End		
MALPRACTICE HISTORY					
28. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement?			Yes	No	☐
29. Has a judgment or arbitration ever been awarded in the amount of $30,000 or more?			Yes	No	☐
A "yes" response to questions 28 – 29 requires a signed and dated written explanation.					
FORMAL DISCIPLINE BY A LICENSING BOARD IN OR OUTSIDE CALIFORNIA WITHIN THE PAST SEVEN (7) YEARS					
These questions refer only to discipline by any hospital, Military or Public Health Service, State Board, or other Government Agency of any U.S. state or territory, Canadian province, or foreign country.					
30. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?			Yes	No	☐
31. Have you ever been denied a license to practice podiatric medicine?			Yes	No	☐
32. Is any denial pending against you?			Yes	No	☐
33. Have you ever had any license to practice podiatric medicine subjected to any disciplinary action?			Yes	No	☐
34. Is any disciplinary action pending against any of your licenses to practice podiatric medicine?			Yes	No	☐
35. Have you ever surrendered a license to practice podiatric medicine?			Yes	No	☐
36. Have you ever had any license to practice podiatric medicine revoked, suspended, or placed on probation?			Yes	No	☐
37. Have you ever had any license to practice podiatric medicine subjected to any action including, *but not limited to*, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?			Yes	No	☐
					P1E

			☐
			☐
			☐
			☐
			☐
43. Have you ever enrolled in, been required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	Yes	No	☐
44. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	Yes	No	☐
45. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice podiatric medicine safely?	Yes	No	☐
46. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice podiatric medicine safely?	Yes	No	☐

PRACTICE IMPAIRMENT OR LIMITATIONS CONTINUED			
47. Do you have any other condition that may in any way impair or limit your ability to practice podiatric medicine safely?	Yes	No	☐
48. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice podiatric medicine safely?	Yes	No	☐
A "yes" response to questions 43 – 48 requires a signed and dated written explanation.			
Applicants who knowingly make a false statement of fact in response to any of the questions on this application, may have their application denied. **If an affirmative answer is given to any of the questions on this application, the Board will assess the nature, the severity and the risks associated with the granting of an unrestricted license, whether conditions should be imposed, or whether you are eligible for a license.**			
FINGERPRINT CLEARANCES FROM BOTH THE DEPARTMENT OF JUSTICE AND THE FEDERAL BUREAU OF INVESTIGATIONS MUST BE RECEIVED PRIOR TO THE ISSUANCE OF A DOCTOR OF PODIATRIC MEDICINE LICENSE IN CALIFORNIA If you have ever been convicted of a misdemeanor or felony, the record of conviction will be reported to the Board as a result of your fingerprint inquiry.			
			P1FB

PHOTOGRAPH AND NOTICE

Affix a 2” by 2” photo here.

Photo must be recent and must be of your head and shoulder areas only

Altered photos are NOT acceptable.

NOTICE OF PERSONAL INFORMATION COLLECTION AND ACCESS: *All items in this application are mandatory, unless otherwise specified. Failure to provide any of the mandatory requested information will delay the processing of your application or its rejection as incomplete. The information provided will be used to determine your qualifications for licensure per section 480 and 2479 of the Business and Professions Code, which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other podiatric or medical licensing authority or the Federation of the Podiatric Medical Boards, or otherwise transferred or disclosed as provided in Civil Code section 1798.24. Applicants have the right to review their application subject to the provisions of the Information Practices Act. Certain information provided may be disclosed to a member of the public, upon request, under the California Public Records Act. The Executive Officer of the Podiatric Medical Board is the custodian of records and may be contacted at 2005 Evergreen St., Ste. 1300, Sacramento, CA 95815, telephone number 916-263-2647.*

APPLICANT DECLARATION

I, _____, certify and declare under penalty of perjury under the laws of the State of California that; (1) I am the person referred to in this foregoing application for a certificate to practice Podiatric Medicine; (2) the photograph included with this application is of me; (3) I have carefully read and thoroughly understand all the requirements; and (4) the statements made in this application and all attachments and submissions are true and correct.

I request that the Podiatric Medical Board of California initiate a review of this application, including all materials submitted as part of this application, to determine my eligibility for licensure in California. In making this request, I authorize the release of any information or records held by any individual or agency, relative to my training and qualifications as a Doctor of Podiatric Medicine upon request by the Board for the use in evaluating my application. I also authorize the release of such information or records for any future investigation by the Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of podiatric medicine.

P1GA

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 and that I am the lawful holder thereof.

I understand that any omission, falsification or misrepresentation of any item or response on this application or any attachment hereto is a sufficient basis for denying or revoking a license.

_____
Applicant Signature

Signed on this _____ day of _____ , _____ at
Day Month Year

_____ , _____ , _____ .
City County State

P1GB

PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

CERTIFICATE OF PODIATRIC MEDICAL EDUCATION

Official Transcripts of **ALL** podiatric medical education must be submitted directly to the Podiatric Medical Board of California to be acceptable. This form must accompany your transcripts. Use one form for each college or university attended. ***Transcript(s) must be mailed directly from the school to the Board to be acceptable.***

TO BE COMPLETED BY APPLICANT:

Please type or print.

Name: **Date of Birth:**

TO BE COMPLETED BY PODIATRIC MEDICAL SCHOOL:

PMBC Use Only

Name of college/university: _____

Address: _____

Date applicant enrolled in school: _____ ☐

Date applicant was issued the degree: _____ ☐

Title of degree awarded: _____ ☐

The undersigned further certifies that the records of this institution show that he/she attended in this institution _____ courses of resident instruction of _____ weeks each, completing at least 4,000 hours (of at least 50 minutes each) in the subjects set forth hereunder (Business and Professions Code Section 2483), and was granted the degree of Doctor of Podiatric Medicine by the above-mentioned podiatric medicine school on the _____ day of _____ _____.

SUBJECTS OF INSTITUTION ☐

Alcoholism and Substance Abuse Detection	Anesthesia	Anatomy (incl. Embryology, Histology and Neuroanatomy)	Behavioral Science
Biomechanics – Foot and Ankle	Biochemistry	Bacteriology, Infectious Disease	Neurology
Child Abuse Detection	Dermatology	Pathology, Microbiology and Immuniology	Podiatric Medicine
Orthopedic Surgery	Geriatric Medicine	Pharmacology (incl. Materia Medica and Toxicology)	Podiatric Surgery
Physical Medicine/Therapy	Human Sexuality	Physical and Laboratory Diagnosis	Physiology
Psychiatric Problem Detection	Medical Ethics	Preventative Medicine (incl. Nutrition)	Therapeutics
Spousal/Partner Abuse Detection	Pediatric Medicine	Radiology and Radiation Safety	Women's Health

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

1. Did student ever take a leave of absence during medical school?	Yes	No	☐
2. Was student ever placed on probation?	Yes	No	☐
3. Was student ever disciplined or placed under investigation?	Yes	No	☐
4. Were any negative reports ever filed by student's instructor(s)?	Yes	No	☐
5. Were any limitations or special requirements imposed on student due to questions of academic or disciplinary problems, or for any other reason?	Yes	No	☐

A "yes" response to questions 1 – 5 requires a signed and dated letter of explanation by school official.

SCHOOL OFFICIAL CERTIFICATION

AFFIX SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct. ☐

PRINTED NAME OF SCHOOL OFFICIAL	TITLE OF SCHOOL OFFICIAL
SIGNATURE OF SCHOOL OFFICIAL	DATE

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that must be attached to this form. Such delegation must be on official letterhead and must be dated within the last 12 months.

P2

PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

REQUEST FOR LETTER OF GOOD STANDING / LICENSE VERIFICATION BY STATE LICENSING AGENCY

If you held, or currently hold a doctor of podiatric medicine license (limited, resident or permanent) in another state, please request a letter of good standing/license verification. Use one form for each state agency where a license is held. ***Verification must be completed and mailed directly from the licensing agency to the Board to be acceptable.***

TO BE COMPLETED BY APPLICANT:

Please type or print.

Name:	
Address:	
City / State / Zip:	
Telephone Number:	**Date of Birth:**
E-mail Address:	

TO BE COMPLETED BY STATE LICENSING AGENCY:

				PMBC Use Only
State/Province:		**License Number:**		☐
Issue Date:		**Expiration Date:**		☐
Status:				☐

UNUSUAL CIRCUMSTANCES

1. Has the license ever been denied, restricted, suspended, terminated or revoked?	Yes	No	☐
2. Is there any action currently pending against the licensee?	Yes	No	☐

A "yes" response to questions 1 – 2 requires a signed and dated letter of explanation by state agency official.

STATE AGENCY OFFICIAL CERTIFICATION

AFFIX STATE SEAL

I certify that this license is valid, current, has never been suspended or revoked, and that records in this office indicate that there are not now, nor have there ever been any charges filed against the holder of this license.

PRINTED NAME OF AGENCY OFFICIAL	TITLE OF AGENCY OFFICIAL
SIGNATURE OF AGENCY OFFICIAL	DATE
WEBSITE	PHONE NUMBER

Note: If any portion of the above certification is deleted or modified, please attach an explanation.

☐

P3

PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA dca DEPARTMENT OF CONSUMER AFFAIRS

CERTIFICATE OF APPROVED RESIDENCY PROGRAM TRAINING

Completion of this form will certify that the applicant referenced below has satisfactorily completed a period of podiatric residency training at this facility and that the applicant has acquired the skill and qualification necessary to safely assume the practice of podiatric medicine in California. Approved Podiatric Residencies Programs are those that have been fully approved by the Council on Podiatric Medical Education. ***Certification must be completed by each residency program and mailed directly from the residency program to the Board to be acceptable.***

TO BE COMPLETED BY APPLICANT:

Please type or print.

Name: **Date of Birth:**

TO BE COMPLETED BY RESIDENCY PROGRAM DIRECTOR:

PMBC Use Only

Name of Resident Program:	
Name of Sponsoring Facility:	
Address of Sponsoring Facility:	

☐

Training start date:		**Training end date:**	
	Date		Date

☐

Residency category:

RPR, POR, PPMR, PMSR, PSR-12, PSR-24, PSR024+, PM&S-24 OR PM&S-36

☐ Completed at least **two years** of this program, is making satisfactory progress and is expected to complete this program on _____ Date

☐ Completed this program on _____ Date

☐

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING

1. Has he/she ever received partial or no credit for a postgraduate training program?	Yes	No	☐
2. Has he/she ever taken a leave of absence or break from your training?	Yes	No	☐
3. Has he/she ever been terminated, dismissed or expelled from a program?	Yes	No	☐
4. Has he/she ever resigned from a program?	Yes	No	☐
5. Was he/she ever placed on probation for any reason?	Yes	No	☐

P4A

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING continued			
6. Was he/she ever disciplined or placed under investigation?	Yes	No	☐
7. Were any incident reports ever filed against him/her?	Yes	No	☐
8. Were any limitations or special requirements placed upon him/her for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	Yes	No	☐
9. Has he/she ever had a postgraduate training program contract not be renewed or offered for a following year?	Yes	No	☐
Program Director: Please provide a signed and dated letter of explanation for any "yes" responses to questions 1 – 9. The explanation must be provided on program letterhead and mailed directly to the Board from the residency program with this form.			

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

I, _____ certify that I am/was the program director
Print Full Name of Residency Program Director

for the above named resident during the residency program dates indicated and that I have carefully read and completed this certification and that the statements made herein are strictly true in every respect.

_____ _____
Signature of Program Director Date

_____ _____
Email Telephone

Attention Program Director: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANTS BY BLOOD, MARRIAGE OR ADOPTION. Only the Residency Program Director may sign this form. If the signature is being delegated to another person, evidence of that must be attached to this form. Such delegation must be on official letterhead and must be dated within the last 12 months.

PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA dca DEPARTMENT OF CONSUMER AFFAIRS

MEMORANDUM OF UNDERSTANDING FOR APPROVED RESIDENCY PROGRAM PARTICIPATION

I, _____ have accepted a residency with _____. I am fully aware that the residency program is an approved program with the Council on Podiatric Medical Education, thereby meeting the postgraduate training requirements for licensure in California.

I am further aware that after completing a licensure application and meeting all the licensure requirements, I will be issued a resident's license by the Podiatric Medical Board of California for practice only in the above-designated residency program. Should I leave the program at any time prior to the expiration date of the resident's license, I will upon that date of departure surrender my resident's license to the Podiatric Medical Board of California. I am entering this program with the full knowledge that if I should not satisfactorily complete the program, no time spent in the postgraduate training program will be credited towards the California licensure requirement.

I certify under penalty of perjury under the laws of the State of California to the truth and accuracy of the above information.

_____
Name (Please print)

_____ _____
Signature Date

P5A

PODIATRIC MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA dca DEPARTMENT OF CONSUMER AFFAIRS

MEMORANDUM OF UNDERSTANDING FOR "*CANDIDATE STATUS*" RESIDENCY PROGRAM PARTICIPATION

I, _____ have accepted a residency with _____ . I am fully aware that the residency program has only "***candidate status***" with the Council on Podiatric Medical Education, and that there is no assurance the program will be formally approved, thereby meeting the postgraduate training requirements for licensure in California.

I am further aware that after completing a licensure application and meeting all the licensure requirements, I will be issued a resident's license by the Podiatric Medical Board of California for practice only in the above-designated residency program. Should the program at any time be notified that it will **not** be approved by the Council on Podiatric Medical Education, I will upon that date surrender my resident's license to the Podiatric Medical Board of California. I am entering this program with the full knowledge that if the program should **not** be approved by the Council on Podiatric Medical Education, or if that approval is **not** retroactive to the time period in which I was a program participant, no time spent in the postgraduate training program will be credited towards the California licensure requirement.

I certify under penalty of perjury under the laws of the State of California to the truth and accuracy of the above information.

_____
Name (Please print)

_____ _____
Signature Date

P5B