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.

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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