

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

**Affidavit
And
Authorization For Release of Information**

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant's Signature (must be signed in the presence of a notary)

Applicant's Printed Last Name

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

Date of Signature

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

NOTARY

Dated _____ Signed _____

State of _____ County of _____

SUBSCRIBED AND SWORN TO before me this _____ day of, _____ 20____

My commission expires: _____ (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: _____ Date: _____

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4220

**REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE
OR PROGRAM DIRECTOR**

Name of applicant: _____

The person named above has applied to the Vermont Board of Medical Practice for a license to practice as a podiatrist in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Name _____ was at _____

from _____ to _____. During that time, he/she

was (list status in the institution): _____

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

The basic medical knowledge to be expected in a podiatrist:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Professional judgement:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Sense of responsibility:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Moral character/ethical conduct:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Competence and skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Podiatrist-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

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REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE
OR PROGRAM DIRECTOR

Name of applicant: _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? Yes No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice as a podiatrist? Yes No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? Yes No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? Yes No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? Yes No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? Yes No

Do you know of any confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? Yes No

Do you know of a failure of the applicant to complete a training program(s)? Yes No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any applicant are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

- Close personal observation
- General impression
- A composite of previous evaluations
- Other – Specify: _____

I further certify that at the time of completion of the above training, or during my association with the podiatrist, he/she was competent to practice as a podiatrist and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. Box 70, Burlington, VT 05402

CERTIFICATE OF PODIATRIC MEDICAL EDUCATION

To be completed by an officer of your School of Podiatric Medicine

I hereby certify that _____ was admitted to the
(Name)

_____ School of Podiatric Medicine in

_____ on _____ and
completed all
(City/State) (Date)

requirements for graduation on _____
(Date)

A _____ was granted on
(specify Certificate/Diploma/Degree) (Date)

Signature of Authorized Officer of the School

Printed Name of Authorized Officer of the School

Date

[Affix Seal]

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

VERIFICATION OF POSTGRADUATE PODIATRIC MEDICAL EDUCATION

To be completed by the Training Program Director:

Name of Institution: _____

Address: _____

If name of the Institution was different when applicant attended please enter name:

I hereby certify that _____ was enrolled
(Name)

in the _____
Program Type (residency, fellowship)

Department (e.g. Radiology, Internal Medicine)

At this institution from _____ to _____
mm/dd/yy mm/dd/yy

During the time of the applicant participation, our postgraduate podiatric medical training met the minimum requirements set by the council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association.

Our records indicate that the applicant received a certificate of completion on

_____ mm/dd/yy

Date: _____

Signed: _____
(Official of the Sponsoring Institution)

(AFFIX SEAL)

Print Name: _____

Title: _____

Return directly to the Board

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. Box 70, Burlington, VT 05402

CERTIFICATE OF PODIATRIC MEDICAL LICENSURE

This section must be completed by the regulatory authority in the States in which you **now hold or have ever held a license to practice medicine.**

I, _____, authorized representative of the _____ State Board of Podiatric Medical Examiners or similar authority, certify that _____ was granted license/certificate number _____ to practice podiatric medicine in the state of _____ on the _____ day of _____.

Based on _____ and that said certificate has never been revoked, suspended or conditioned in any way, or the licensee/certificate holder has never been disciplined by this authority in any way.

NOTE: If licensed/certified by written examination the authorized representative should further certify:

I further certify that the aforesaid _____ in his/her written examination before this Board, obtained a general average of _____ percent in the following branches: **(The subjects of the examination and rating of each must be stated in full)**

Signature of authorized representative

Printed Name of authorized representative

[Affix Seal]

Date

REQUEST FOR NBPME SCORES

Please print firmly and complete all items. Send this form to:

THOMSON PROMETRIC-NBPME

2000 LENOX Drive, 3rd Floor, Lawrenceville, NJ 08648

Phone: 877-302-8952

Date _____ Year of Graduation _____ Social Security # _____ OPTIONAL

Check scores to be sent: Part I _____ Part II _____ Phone _____

← This is a mailing label
Please print your full name and address.

FEE: \$35.00

The fee covers the transmittal of Part I and Part II scores and must accompany each request.

Make check payable to NBPME.

Your signature

A copy is forwarded to the address listed below with your NBPME scores.

A copy remains in our office file.

Please retain a copy for your file.

This is a mailing label

Please print below the exact name, office, and address to which scores are to be sent.

NAME
ADDRESS
CITY/STATE/ZIP

NAME
ADDRESS
CITY/STATE/ZIP

Date scores sent _____
Board Use Only

Federation of Podiatric Medical Boards

PMLexis/Part III Score & Disciplinary Reports

Please fill out the form below to request your PMLexis/Part III Score Reports or Disciplinary Reports to be sent to State Boards only. Personal reports cannot be sent to individuals. On the next screen you will have the option to pay online by credit card or to print out a form to mail in with a check.

MANAGED CARE GROUPS: Managed Care Groups must send reports by mail (click [here](#) for address). This form is reserved strictly for individuals ordering reports to be sent to State Boards.

First Name:	<input type="text"/>
Middle Name: (optional)	<input type="text"/>
Last Name:	<input type="text"/>
Maiden Name: (optional)	<input type="text"/>
Date Of Birth: (use 4-digit year)	<input type="text"/> (Sample: 1/1/1900)
Social Security Number:	<input type="text"/> (Sample: 123-45-6789)
Phone Number:	<input type="text"/> (Sample: 561-555-1212)
E-Mail Address:	<input type="text"/>

ADDRESS

(If you plan on paying by credit card, this address must match the address on file with your credit card. If you plan on paying by check and mailing your request, use your mailing address.)

Address:	<input type="text"/>
Address (line 2): (optional)	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text" value="[Select a State]"/>
Zip Code:	<input type="text"/> (Sample: 00000)

MAILING ADDRESS

Click this box if your Mailing address is different than above.

You must make at least one selection below. It is permissible to select both.

Click this box to request PMLexis/Part III Score Reports.

Click this box to request Disciplinary Reports.

TOTAL CHARGES: \$0.00*

*Disciplinary reports are offered at a reduced rate when sent to State Boards who are paid up members of the Federation of Podiatric Medical Boards.

Customer Service: 561-752-3735 / Privacy Policy & Security Statement

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