OKLAHOMA STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

APPLICATION FOR LICENSURE

PRINT OR TYPE ANSWERS TO **ALL QUESTIONS** ON THIS FORM **IN FULL:**

1.

LAST NAME: _____

FIRST NAME: _____

MIDDLE NAME: _____

SUFFIX: _____SOC SEC NUMBER:_____

MAILING ADDRESS: _____

STREET / P.O. BOX: _____

CITY: _____

STATE: _____ZIP CODE_____

DATE OF BIRTH

____/____/____ CITY:_____

STATE:_____COUNTRY:_____

PLACE OF BIRTH

PRACTIC ADDRESS:

_____

STREET / P.O. BOX: _____

CITY: _____

STATE: _____ZIP CODE_____

CONTACT PHONE NUMBER:_____

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2. RACE: CAUCASIAN☐ BLACK☐ AM. INDIAN☐ HISPANIC☐ OTHER(specify) _____ SEX: M☐ F☐

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3. HAVE YOU TAKEN THE NATIONAL BOARD OF PODIATRIC MEDICAL EXAMINERS EXAMINATION?

YES ☐ NO ☐

STATUS: PENDING ☐ DIPLOMATE ☐

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4. LIST ALL OF THE STATES IN WHICH YOU NOW HOLD OR HAVE EVER HELD A PERMANENT, TEMPORARY, LIMITED OR INSTITUTIONAL LICENSE TO PRACTICE PODIATRIC MEDICINE, IN ORDER OF ATTAINMENT.

A. _____ B. _____ C. _____

D. _____ E. _____ F. _____

G. _____ H. _____ I. _____

5.

MOUNT PHOTOGRAPH HERE

AFFIX SEAL PARTIALLY ON PHOTO,

PARTIALLY ON APPLICATION

THIS PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE PAST TWELVE MONTHS.

THIS IS TO CERTIFY THAT THE PHOTOGRAPH IS A CORRECT LIKENESS OF THE APLICANT.

_____

NOTARY PUBLIC

COMMISSION NUMBER:_____

MY COMMISSION EXPIRES:_____

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

DATE APPLICATION RECEIVED _____

DATE FEE RECEIVED _____

AMOUNT RECEIVED_____

DATE WITHDRAWN _____

DATE REJECTED _____

DATE APPROVED_____

DATE LICENSED ISSUED_____

LICENSE NUMBER_____

COMMENTS: _____

_____

_____

6. ANSWER THE FOLLOWING QUESTIONS: (YES ANSWERS MUST BE EXPLAINED IN A SWORN AFFIDAVIT)

HAS YOUR APPLICATION FOR EXAMINATION OR LICENSURE EVER BEEN REJECTED IN THIS OR ANY OTHER STATE? YES☐ NO☐

HAVE YOU EVER FAILED AN EXAMINATION FOR LICENSURE? IF SO, HOW MANY TIMES?_____ YES☐ NO☐

HAS YOUR LICENSE EVER BEEN REVOKED OR HAVE YOU EVER BEEN THE SUBJECT OF DISCIPLINARY ACTION BY A LICENSING AGENCY? YES☐ NO☐

HAVE YOU EVER BEEN CHARGED WITH OR CONVICTED OF A FELONY OR MISDEMEANOR? (OTHER THAN TRAFFIC VIOLATIONS) YES☐ NO☐

ARE YOU NOW OR HAVE YOU EVER BEEN ADDICTED TO OR USED IN EXCESS, ANY DRUG OR CHEMICAL SUBSTANCE INCLUDING ALCOHOL? YES☐ NO☐

ARE YOU NOW BEING TREATED OR HAVE YOU EVER BEEN TREATED THROUGH A DRUG OR ALCOHOL REHABILITATION PROGRAM? YES☐ NO☐

ARE YOU NOW OR HAVE YOU EVER BEEN TREATED FOR EMOTIONAL OR MENTAL DISORDERS? YES☐ NO☐

HAVE YOU EVER BEEN CHARGED WITH OR CONVICTED OF A CRIME DIRECTLY OR INDIRECTLY RELATED TO YOUR PRACTICE OF PODIATRY? YES☐ NO☐

HAVE YOU EVER VOLUNTARILY SURRENDERED YOUR PODIATRY LICENSE OR NARCOTIC PERMIT (STATE OR FEDERAL)? YES☐ NO☐

HAVE YOU EVER BEEN DENIED MEMBERSHIP IN A STATE OR COUNTY PODIATRIC SOCIETY? YES☐ NO☐

HAVE YOU EVER BEEN DENIED HOSPITAL OR STAFF PRIVILEGES? YES☐ NO☐

HAVE YOU EVER ENTERED INTO AN AGREEMENT WITH A FEDERAL, STATE, OR LOCAL JURISDICTIONAL BODY TO AVOID FORMAL ACTION? YES☐ NO☐

HAVE YOU EVER BEEN THE SUBJECT OF DISCIPLINARY ACTION BY A HOSPITAL? YES☐ NO☐

HAVE YOU EVER BEEN NAMED AS A DEFENDANT IN A CIVIL SUIT (INCLUDE MALPRACTICE)? YES☐ NO☐

HAVE YOU EVER BEEN REPORTED TO THE NATIONAL PRACTITIONERS DATABANK (NPDB)? If so, enclose copy of report. YES☐ NO☐

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7. DISCLAIMER: The information requested below is for statistical purposes ONLY. The completion of Section 7 is strictly voluntary and will not effect the processing of your application for licensure.

1. IF LICENSED, WHERE DO YOU INTEND TO LOCATE?

_____

_____

2. WHY DO YOU SEEK LICENSURE IN THE STATE OF OKLAHOMA?

_____

_____

3. HAVE YOU EXECUTED OR BEEN OFFERED A CONTRACT IN CONNECTION WITH PRACTICE IN THE STATE OF OKLAHOMA? IF SO, PLEASE IDENTIFY WITH WHICH CATEGORY:

HOSPITAL_____ESTABLISHED PRACTICE_____

HEALTH CARE CORPORATION (HMO, PPO, IPA, etc.)_____

OTHER:_____

4. DO YOU PLAN ON JOINING ANY MEDICAL ORGANIZATION(S)? IF YES, WHICH ONES?

_____

5. WILL A FAMILY ACCOMPANY YOU TO OKLAHOMA? IF YES, IS ANY MEMBER OF THAT FAMILY TRAINED IN ANY CATEGORY OF THE HEALTH PROFESSIONS? IF YES, WHICH ONES? IF THEY ACCOMPANY YOU DO THEY PLAN TO SEEK EMPLOYMENT IN THEIR PROFESSIONAL CATEGORY?

_____

_____

6. WILL YOUR PROFESSIONAL LIABILITY INSURANCE POLICY COVER YOUR PRACTICE IN OKLAHOMA? IF NOT, WHEN DO YOU EXPECT TO OBTAIN LIABILITY INSURANCE THAT WILL COVER PRACTICE IN OKLAHOMA?

_____

8.

TEACHING APPOINTMENTS: (Please give description, dates, institution and address)

_____
Institution City/State Appointment Date

_____
Institution City/State Appointment Date

_____
Institution City/State Appointment Date

_____
Institution City/State Appointment Date

9.

EDUCATION	POST-GRADUATE TRAINING
HIGHSCHOOL:______________________	HOSPITAL:______________________
CITY:______________ STATE OR COUNTRY: ____________	CITY:______________ STATE OR COUNTRY: ____________
MO/YR ENTERED: _____ / _______ MO/YR GRADUATED:_____ / _____	MO/YR ENTERED: _____ / _______ MO/YR COMPLETED:_____ / _____
TYPE OF DEGREE:______________________	SPECIALTY:______________________
PRE-MEDICAL:______________________	HOSPITAL:______________________
CITY:______________ STATE OR COUNTRY: ____________	CITY:______________ STATE OR COUNTRY: ____________
MO/YR ENTERED: _____ / _______ MO/YR GRADUATED:_____ / _____	MO/YR ENTERED: _____ / _______ MO/YR COMPLETED:_____ / _____
TYPE OF DEGREE:______________________	SPECIALTY:______________________
PRE-MEDICAL:______________________	HOSPITAL:______________________
CITY:______________ STATE OR COUNTRY: ____________	CITY:______________ STATE OR COUNTRY: ____________
MO/YR ENTERED: _____ / _______ MO/YR GRADUATED:_____ / _____	MO/YR ENTERED: _____ / _______ MO/YR COMPLETED:_____ / _____
TYPE OF DEGREE:______________________	SPECIALTY:______________________
PODIATRY SCHOOL:______________________	HOSPITAL:______________________
CITY:______________ STATE OR COUNTRY: ____________	CITY:______________ STATE OR COUNTRY: ____________
MO/YR ENTERED: _____ / _______ MO/YR GRADUATED:_____ / _____	MO/YR ENTERED: _____ / _______ MO/YR COMPLETED:_____ / _____
TYPE OF DEGREE:______________________	SPECIALTY:______________________
PODIATRY SCHOOL:______________________	HOSPITAL:______________________
CITY:______________ STATE OR COUNTRY: ____________	CITY:______________ STATE OR COUNTRY: ____________
MO/YR ENTERED: _____ / _______ MO/YR GRADUATED:_____ / _____	MO/YR ENTERED: _____ / _______ MO/YR COMPLETED:_____ / _____
TYPE OF DEGREE:______________________	SPECIALTY:______________________
POST-GRADUATE SCHOOL:______________________	HOSPITAL:______________________
STATE OR CITY:______________ COUNTRY: ____________	CITY:______________ STATE OR COUNTRY: ____________
MO/YR ENTERED: _____ / _______ MO/YR GRADUATED:_____ / _____	MO/YR ENTERED: _____ / _______ MO/YR COMPLETED:_____ / _____
TYPE OF DEGREE:______________________	SPECIALTY:______________________

10. **PRACTICE HISTORY AND NON-MEDICAL ACTIVITY (DO NOT INCLUDE TRAINING)**
ACCOUNT FOR ALL DATES IN CHRONOLOGICAL ORDER

FROM MO/YR	TO MO/YR	CITY	COUNTRY OR STATE	EMPLOYER OR PRACTICE SETTING (CLINIC, HOSP., SOLO PRAC., ETC)	SPECIALTY OR ACTIVITY
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________
___/___	___/___	____________	________	________________________	_________

11. **CURRENT PRACTICE SETTING**

DATE STARTED (MO/YR)		CITY	COUNTRY OR STATE	EMPLOYER OR PRACTICE SETTING (CLINIC, HOSP., SOLO PRAC., ETC)	SPECIALTY
___/___	___/___	____________	________	________________________	_________

12.

HEALTH CERTIFICATE:

I _____, A LEGALLY QUALIFIED PHYSICIAN IN THE STATE OF

_____ HEREBY CERTIFY THAT I HAVE MADE A CAREFUL PHYSICAL

EXAMINATION OF THE APPLICANT ON THE DATE _____ / _____ / _____ ; THAT IN MY OPINION HE/SHE IS IN GOOD MENTAL AND

PHYSICAL HEALTH, FREE OF ANY SERIOUS COMMUNICABLE DISEASE; AND THAT HE/SHE IS PHYSICALLY AND MENTALLY FIT TO

PRACTICE PODIATRY.

_____ M.D.

SEAL

SWORN TO BEFORE ME: _____ _____NOTARY PUBLIC

COMMISSION NUMBER:_____ COMMISSION EXPIRATION:_____

13.

APPLICANT'S OATH

I, _____, hereby swear or affirm under oath that I am the person named in the application for license to practice podiatry in the State of Oklahoma, that all statements I have made herein are true; that I am the original and lawful possessor of the podiatry school diploma submitted herewith as a credential by photographic reproduction; that the photograph is a true resemblance of me and was made within the last 12 months; that in consideration of the issuance to me of a license to practice podiatry in the State of Oklahoma I hereby pledge that I shall abstain from deceptive or fraudulent methods of practice, from immoral, unprofessional and unethical conduct; I shall abstain from professional association with, and shall not act as a shield for, an unlicensed practitioner or other person and I hereby agree that violation of this pledge shall constitute cause for the revocation of my podiatry license.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Oklahoma State Board of Podiatry or its successors any information, files or records requested by that Board in connection with this application. I further authorize the Oklahoma State Board of Podiatry or its successors to release to the organizations, individuals or groups listed above any information that is material to this application or any subsequent licensure or licensure renewal.

I, _____, D.P.M. CERTIFY THAT I HAVE☐ HAVE NOT☐ BEEN INVOLVED IN A MALPRACTICE CLAIM. (IF YOU CHECKED YES, EXPLAIN FULLY IN DETAIL BY A SWORN AFFIDAVIT)

_____,D.P.M.
APPLICANT'S SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____, _____.

_____
NOTARY PUBLIC

COMMISSION NUMBER:_____ COMMISSION EXPIRATION:_____

(SEAL)

MAIL APPLICATION AND ALL DOCUMENTS, FORMS, ETC. TO:

OKLAHOMA STATE BOARD OF PODIATRIC MEDICAL EXAMINERS
P.O. BOX 18256
OKLAHOMA CITY, OK 73154-0256

(405) 962-1400