



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
<http://tn.gov/health/topic/Podiatric-board>**

**INSTRUCTIONS FOR LICENSURE AS A PODIATRIST
(615)741-5735, or (800)778-4123 ext. 741-5735**

The enclosed application and instructions are pertinent for those podiatrists who are applying for licensure based on examination or reciprocity or for an academic license.

Please carefully read the information below to determine the method of licensure for which you will be applying and follow the instructions for the selected method. The requirements for application are supported by T.C.A. Sections 63-3-101 through 63-3-127, T.C.A. Sections 63-1-101 through 63-1-138 and Rules and Regulations Chapters 1155-2-.01 through 1155-2-.09, which are included with the application packet.
<http://share.tn.gov/sos/rules/1155/1155.htm>

It is suggested all documents listed in the instructions be requested from the appropriate institutions or individuals upon receipt of this package. All supporting documents must be received in the Board's administrative office by the time frames indicated in the instructions. Please allow ten (10) working days for the information submitted to be received and placed in your file. Mail delivered by Federal Express and other special courier services will be handled as routine mail.

METHODS OF LICENSURE

ACADEMIC - The licensure method for individuals who have met all requirements for full and unrestricted Podiatry licensure except for post graduate training and/or licensing examinations. This license allows a Podiatrist to enter into an internship.

EXAMINATION - The licensure method for individuals who have received the degree of Doctor of Podiatric Medicine and who have successfully completed the National Board Examination and who have completed at least a one-year residency program approved by the Council on Podiatric Medical Education. If you wish to apply for licensure by examination go to Section I for the appropriate instructions.

RECIPROCITY - The licensure method for Podiatrists who hold a current and valid license in another state provided the license requirements in the other state are substantially the same as those required in Tennessee. If you wish to apply for licensure by reciprocity go to Section II for the appropriate instructions.

PLEASE NOTE – Rule 1155-02-.08 (4) Examination scores obtained by an applicant in order to apply for licensure as a podiatrist shall be effective for five (5) years from the date that the applicant took the examination or the last part of the examination, should the examination be given in multiple parts.

SECTION I - Instructions for licensure by Examination or Reciprocity or for Academic License

The following items must be submitted to the Board Office no later than sixty (60) days prior to the next scheduled examination.

1. Completed and notarized application indicating method of requested licensure.
2. To apply by exam or reciprocity an application fee of four hundred and forty dollars (\$440) and a state regulatory fee of ten dollars (\$10) is needed for a total of (\$450).
3. One (1) recent passport type (2 x 2) photograph taken within the preceding twelve (12) months, which is signed by the applicant.
4. All applicants must complete the Declaration of Citizenship form and have it notarized. The form can be found at: <http://tn.gov/assets/entities/health/attachments/PH-4183.pdf>
5. Official transcript sent directly to the Board Office from the school of Podiatry from which you graduated. The transcript must indicate date graduated and degree awarded.
6. An applicant shall submit evidence of good moral character. Such evidence shall be three (3) recent (within the preceding 12 months) original letters, two of which must be from licensed podiatrists, medical doctors or osteopathic physicians attesting to the applicant's personal character and professional ethics on the signatory's letterhead.
7. An applicant shall submit proof of being eighteen (18) years of age or older. Acceptable proof is a certified/notarized copy of the applicant's birth certificate, drivers license, or voters registration card.
8. **A criminal background check is required.** For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions>.
9. Complete and submit along with your application the *Practitioner Profile Questionnaire* which is online at <http://tn.gov/assets/entities/health/attachments/PH-3585.pdf>. You are **required** by law to update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action.
10. Verification of successful completion of Parts I and II of the National Board Examination sent directly from the National Board to the Tennessee Board's office. You may request a score at: <http://www.apmlc.com/>
11. Verification of successful completion of the following: Use Attachment 1:

Certificate of completion of at least a one (1) year residency program approved by the Council on Podiatric Medical Examinations or its successor organization. **If the residency program is longer than one (1) year, the entire program must be completed before you can be licensed.** This form must be completed and forwarded to the Board's office.
12. Request verification that your residency program is accredited by the Council on Podiatric Medical Education be sent to the board administrative office. This requires a fee payable to the Council on Podiatric Medical Education, 9312 Old Georgetown Rd, Bethesda MD 20814.
13. Request a disciplinary action report from the Federation of Podiatric Medical Boards. Reports can be ordered online at www.fpmb.org. This requires a fee. You may also write to the Federation of Podiatric Medical Boards, 12116 Flag Harbor Dr, Germantown MD 20874-1979 and request a report.

14. Please request VERIFICATION OF LICENSURE from all states in which you hold a current license or have ever held a license in podiatry or any other profession. This verification must be sent directly to the board's administrative office from the other state.
15. If you have taken the PMLexis exam in another state, request that verification of your scores be sent to the board administrative office. Reports can be ordered online at www.fpmb.org. There is a fee required. You may also write to the Federation of Podiatric Medical Boards, 12116 Flag Harbor Dr, Germantown, MD 20874-1979. **(If applying for Academic License, do not request this information.)**

A completed file is one which contains ALL of the required documentation.

Applicants will be notified when they have been approved for the Jurisprudence exam

RE-EXAMINATION

Applicants who fail Part III of the NBPME examinations shall be entitled to retake the next regularly scheduled examination upon a written request to the Board's administrative office at least sixty (60) days prior to the examination.

A completed file is one which contains ALL of the required documentation.

All files completed thirty (30) days prior to a regularly scheduled Board meeting will be presented to the Board for review at that meeting.

ATTACH
PHOTO
HERE



Exam/Recip

For office use only
2215) 001 \$ 440
2215) 006 \$ 10

Tennessee Board of Podiatric Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
<http://tn.gov/health/topic/Podiatric-board>

APPLICATION FOR LICENSURE AS A PODIATRIST

PLEASE CHECK ONE: Examination Reciprocity Academic

Name: _____
 Last First Middle Maiden

Current Home Mailing Address: Current Practice Name and Address: *

*If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.

Phone (Home): _____ (Work): _____

U. S. CITIZEN: Yes ___ No ___ Entitled to Live and Work in the U.S.: Yes ___ No ___
All applicants **must** complete the Declaration of Citizenship form and have it notarized.

Social Security Number: _____ - _____ - _____ Date of Birth: _____

E-Mail: _____
Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. Yes ___ No ___

Gender: Female ___ Male ___ Race: _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ___ No ___

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)
Yes ___ No ___

Have you ever been known by any other names besides what is listed above? Yes ___ No ___

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:

PRE-MEDICAL EDUCATION:

NAME OF SCHOOL

DATES ATTENDED

DEGREE

- A. _____
- B. _____
- C. _____

PODIATRY EDUCATION

- 1st year Name _____
 Address _____
 Dates _____
- 2nd year Name _____
 Address _____
 Dates _____
- 3rd year Name _____
 Address _____
 Dates _____
- 4th year Name _____
 Address _____
 Dates _____

POST GRADUATE STUDY OR WORK

Are you currently enrolled in a Residency program? Yes _____ No _____

If yes; Name of residency: _____

Address: _____

Director: _____

Following completion of your residency program, do you plan to practice in Tennessee? Yes _____ No _____

Have you completed:

At least a one (1) year residency? Yes _____ No _____

*Ten (10) years of practice as a podiatrist in another state prior to 1990? Yes _____ No _____

*If yes, please explain fully on a separate sheet.

Have you taken the National Board Examination?

Part I YES ___ NO ___
Part II YES ___ NO ___

Have you ever taken a podiatry licensing examination in another state? Yes _____ No _____

If YES what state(s) _____

If YES was it:	A state exam _____	Pass _____	Fail _____
	PMLexis _____	Pass _____	Fail _____
	Other _____	Pass _____	Fail _____

Explain: _____

(Have verification of your scores sent directly to the Board)

LICENSURE INFORMATION

List below states in which you have ever been or are currently licensed as a podiatrist.

STATE LICENSED	LICENSE NUMBER	DATE ISSUED
_____	_____	_____
_____	_____	_____
_____	_____	_____

List below states in which you hold a license as a health professional other than a Podiatrist

STATE LICENSED	LICENSE NUMBER	DATE ISSUED
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Request Verification of Licensure" be sent directly to this board from each state in which you now hold or have ever held licensure.)

EMPLOYMENT INFORMATION

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

<u>Company/ Employer:</u>	<u>Address:</u> (City, and State)	<u>Position:</u>	<u>Duties:</u>	<u>Dates</u>	
				<u>From:</u> Mo./Yr.	<u>To:</u> Mo./Yr.
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

COMPETENCY QUESTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
 - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
6. **"Illegal use of illicit or controlled substances"** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.

YES NO

- | | | | |
|----|---|-----|-----|
| 1. | Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? | ___ | ___ |
| 2. | Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? | ___ | ___ |

If so, please list: _____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.]

- 3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances? ___ ___
- 4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of illicit or controlled substances? ___ ___
- 5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature? ___ ___
- 6. Have you ever held or applied for a license, privilege, registration or certificate to practice dentistry in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? ___ ___
- 7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? ___ ___
- 8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action? ___ ___
- 9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended? ___ ___
- 10. Have you ever been rejected or censured by a professional association or society? ___ ___
- 11. In relation to the performance of your professional services in any profession:
 - a. Have you ever had a final judgment rendered against you; ___ ___
 - b. Have you ever entered into any settlement of any legal action; or ___ ___
 - c. Are there any legal actions pending against you or to which you are a party? ___ ___
- 12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction? ___ ___
- 13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state) ___ ___

AFFIDVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*

being duly sworn and identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a podiatrist in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a podiatrist.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE



Tennessee Board of Podiatric Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
<http://tn.gov/health/topic/Podiatric-board>

**CERTIFICATE OF COMPLETION OF AT LEAST A ONE-YEAR
RESIDENCY PROGRAM**

This is to certify that _____, a participant of
Applicant's name
_____, participated in an approved residency program offered by
Name of Program

Name and Address of Facility

from _____ thru _____ and that the above named participant will successfully complete this
Date Date
program on _____
Date

_____, certifies and says he/she is/was the program director
for the participant named above during the program indicated and that he/she has carefully read and completed
this form and that the statements made herein are strictly true in every respect.

Type or Print Name of Program Director

Address

Phone Number () _____

Signature of Program Director

NOTE: Approved podiatric residencies are those programs approved by the Council on Podiatric Medical Education.