Tennessee Board of Podiatric Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

AFFIDAVIT OF ACCREDITATION OF RESIDENCY PROGRAM

If you have completed an approved Residency program, Please complete Section I and send this form to the AMERICAN PODIATRIC MEDICAL ASSOCIATION for verification of an approved Residency, at the following location:

American Podiatric Medical Association, Inc.
9312 Old Georgetown Road
Bethesda, MD 20814
(301) 571-9200 or
1-800-ASK-APMA

SECTION I

Name of Applicant

Name of Residency Program

Date of Residency

Address of Residency Program

Director of Residency Program

SECTION II - THIS SECTION MUST BE COMPLETED BY AN AUTHORIZED REPRESENTATIVE OF THE AMERICAN PODIATRIC MEDICAL ASSOCIATION.

This will verify that the above named Residency Program has been granted full accreditation by the American Podiatric Medical Association.

Name - Please Print or Type

NOTARY

SEAL

Signature

Title

Date

Subscribed and sworn before me this _____ day of _____, 20 _____.

(Notary Seal)

Notary

My commission expires _____

Please return to: Address listed above