Verification of Post-Graduate Training

Each supervisor must complete a separate form. The total of all forms must equal 24 months.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

EMPLOYMENT INFORMATION

To be completed by the Evaluating Physician.

Evaluating Hospital/Institution: _____

Evaluating Physician: _____ **License Number:** _____

Email: _____ **Telephone Number:** _____

Is this training program accredited by the Council on Podiatric Education? ☐ Yes ☐ No, please attach an explanation.

Dates of Employment/Supervision: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

☐ **Yes** ☐ **No** **Did the applicant successfully complete this training program? If no, please attach an explanation.**

Please answer "yes" or "no" to each of the following questions, do not leave any question blank.
For any "yes" answers, please attach additional supporting documentation to this form.

☐ Yes ☐ No Did the applicant ever take a leave of absence or break from their training?

☐ Yes ☐ No Was the individual ever placed on probation?

☐ Yes ☐ No Was the individual ever disciplined or placed under investigation?

☐ Yes ☐ No Were any negative reports for behavioral reasons ever filed by instructors

☐ Yes ☐ No Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?

☐ Yes ☐ No Was the individual ever asked to leave a training or post-graduate program?

I do hereby certify that the applicant for licensure as a licensed podiatric physician has successfully completed the above post-graduate residency program. I further certify that the applicant is qualified and competent to practice as a podiatric physician.

Signature of Evaluating Physician: _____ **Date:** _____