KENTUCKY BOARD OF PODIATRY

P.O. Box 1360
Frankfort, KY 40602
Phone (502) 892-4259
Fax (502) 564-4818
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APPLICATION FOR PODIATRY LICENSE

Your full name, social security number, and date of birth are essential for identification purposes. Please supply this key information.

There is space for two addresses on the application, a public mailing address and a restricted use address. The public mailing address is the address where the Board will send all mail. The restricted use address is the street address where you reside and is not public information, unless it is the same as your public mailing address.

GENERAL INFORMATION

Soc. Sec. No.:_____ Date of Birth:_____

Last Name:_____ Maiden Name: _____

First Name:_____ Middle Name:_____

Gender (Male or Female):_____

PUBLIC MAILING ADDRESS

Street:_____

City:_____ State:_____ Zip:_____ County:_____

Telephone:_____ Fax:_____

Email:_____

RESTRICTED USE ADDRESS

Street:_____

City:_____ State:_____ Zip:_____ County:_____

Telephone: (home) _____ (cell) _____

(work) _____

UNDERGRADUATE EDUCATION REQUIREMENT: (Use additional sheets if necessary)

COLLEGE:

Name:_____ Dates Attended: _____ to _____

City and State:_____ Date of Graduation: _____

Name:_____ Dates Attended:_____ to _____

City and State:_____ Date of Graduation: _____

PODIATRIC EDUCATION REQUIREMENT

COLLEGE

Name:_____ Dates Attended:_____ to _____

City and State:_____ Date of Graduation: _____

PROFESSIONAL EXAMINATION REQUIREMENT:

Answer "Yes" or "No"

_____ NBPME Part I, Date(s) Taken:_____ Passed _____

_____ NBPME Part II, Date(s) Taken:_____ Passed _____

_____ NBPME Part III, Date(s) Taken:_____ Passed _____

CHARACTER REFERENCES

Please have three (3) letters of recommendation sent the Board verifying that you are of good moral character and not addicted to alcohol or drugs. These letters should be from non-family members.

LICENSES:
List all licenses, registrations, or certifications issued by any state which you now hold or have ever held in a regulated profession. Use additional sheets if necessary.

(1) Issuing State:_____

Profession:_____

Date Verification Was Requested:_____

(2) Issuing State:_____

Profession:_____

Date Verification Was Requested:_____

(3) Issuing State:_____

Profession:_____

Date Verification Was Requested:_____

The following states have refused to issue a verification of licensure directly to me and will send the document directly to the Board. Use additional sheets if necessary.

Issuing State:_____

Date Verification Was Requested:_____

NOTE: We MUST have a verification of licensure directly from the state or jurisdiction in which you hold, or have held a license. A printed verification from the state Board's website is NOT sufficient. Be sure to request the verification in sufficient time for the Board to process it and get it to us at least 20 days prior to our next examination date.

LIST ALL PRECEPTORSHIP/RESIDENCY PROGRAMS YOU HAVE PARTICIPATED IN (Whether completed or not)

Name:_____ Dates Attended: _____ to _____

City and State:_____ Date of Completion: _____

Type of Program _____ Reason for Departure (if not completed) _____

_____

Name:_____ Dates Attended: _____ to _____

City and State:_____ Date of Completion: _____

Type of Program _____ Reason for Departure (if not completed) _____

_____

If you are now or have served in the Military Service list Branch of Service, Rank and name and address where you served:

_____

_____

If you hold a license to practice medicine in other States or Commonwealths list by name, license numbers and if CME credit is needed for renewal:

_____

_____

_____

List any sanctions, restrictions, suspensions or revocations against your licenses, name and address of State or Commonwealth:

_____

_____

_____

Have you defaulted on a student loan through KHEAA or the state of Kentucky? ___Yes ___No

List any criminal suit against you that is pending or that you have been convicted of (include name of City, County, State and Court:

_____

_____

_____

If you have a drug or alcohol dependency, other than prescribed for a valid disease, name the substance and give the particulars of treatment:

_____

_____

_____

List memberships in medical societies by name and address:

_____

_____

_____

PRACTICE HISTORY:

List all clinics, practitioners, and locations you have been affiliated with or practiced at during the past 10 years. Use additional sheets if necessary.

1. Name of Facility/Practitioner:_____

   Address:_____

   Dates of Employment:_____ to _____ Hours worked each week:_____

   Duties/Responsibilities:_____

   _____

2. Name of Facility/Practitioner:_____

   Address:_____

   Dates of Employment:_____ to _____ Hours worked each week:_____

   Duties/Responsibilities:_____

   _____

Notarized affidavit of Applicant:

I certify that the statements contained in this application are true, complete and correct and that they shall form the basis of my application.

_____ _____

Signature of Applicant Date

I certify that this application was sworn and subscribed before me by _____

_____, whose signature appears herein, on this _____ (day) of

_____ (month), _____ (year)

My Commission expires the _____ (day) of _____ (month), _____ (year)

Signature:_____

APPLICATION REQUIREMENTS:

1. Attach a dated photo of yourself taken within the past 6 months. Sign your name in the left margin of the photo.

2. Attach a check or money order for $300.00 made payable in U.S. Funds to KENTUCKY BOARD OF PODIATRY. Application fees are nonrefundable regardless of circumstances.

5. Have the appropriate schools, colleges or institutions send OFFICIAL transcripts directly to the Kentucky State Board of Podiatry. Copies of transcripts sent by the applicant are not accepted. ***OFFICIAL means it MUST be received in a SEALED ENVELOPE, directly from the institution, agency or school.***

a. Undergraduate colleges or universities
b. Graduate colleges or universities
c. Podiatry, medical, dental schools or colleges
d. Clinical evaluations from podiatry school
e. List of 4th year rotations or externships
e. National Board Certification for Part I, II and III (PM Lexis)
f. National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank (www.npdb-hipdb.com) (students or new graduates who have no other state licenses are exempt)
g. Primary source verification of licenses from other states including any disciplinary action, sanctions, or suspension of license. Printed verification from the state's website, or a copy of a current license is NOT sufficient.
h. FBI background check (results are to be sent directly to the Board of Podiatry)