

COMMONWEALTH OF PUERTO RICO
PUERTO RICO BOARD OF
PODIATRY MEDICAL EXAMINERS
CALL BOX 10200 SANTURCE, PUERTO
RICO 00908-0200 TEL. 725-8161

APPLICATION FOR LICENSE TO PRACTICE PODIATRY MEDICINE IN PUERTO RICO

Warning: Any false statement knowingly made by the applicant or connived at by him in any clause in this application, shall be sufficient cause for rejection or revocation of license after it has been granted.

I hereby make application for an examination to obtain a license to practice Podiatry Medicine in Puerto Rico, and submit the following statements under oath:

AFFIDAVIT

An unmounted bust photograph of applicant, taken not more than six months before the date of application, must be pasted in this space and must not be large than the space provided and must not be smaller than 2 1/2 by 2 1/2 Inches. (Passport photographs requested.)

State or territory of

Country or City of

I _____ being duly sworn, state that I am the person referred to in this application that the statements here in contained are true in every respect, and that the attached photograph is a true likeness of myself taken within the last six months.

Signature of Applicant

Subscribed and sworn to before me this

day of _____ Witness my
hand and seal here unto attached. My
commission expires on

(SEAL)

Signature of Notary Public

THE APPLICANT MUST GIVE FULL ANSWERS TO THE FOLLOWING

Name _____ Age _____
Date of Birth _____ Place of Birth _____
(Month, Day, Year) (City, Country/State)
In a bona fide resident of _____

Phone: _____ (home) _____ (work)

The answer to this application may be sent to _____

Native of _____ Complexion _____ Color of hair _____
Color of Eyes _____ Height _____ Weight Marks _____

Are you a citizen of the United States?
date and place of naturalization

If naturalized, give

Has your surname ever been changed?
such change

If so, give date and place of
Give original surname

Have you ever practiced Podiatry Medicine illegally?
ever been convicted of, or indicted for, any crime?

Have you

If so, state facts in the case here or on separate sheet and attach:

Have you read carefully and fully understand the laws containing the
information and rules governing the examination? Answer Yes or No

Are you free from contagious disease?

I hereby expressly waive all provisions of law forbidding any physician
or other person who has attended or examined me, or who hereafter attend or
examine me from disclosing any knowledge or information which he thereby
acquired and I hereby consent that he may disclose such knowledge or
information to the Puerto Rico Board of Podiatry Medical Examiners.

HIGH SCHOOL EDUCATION

NAME AND LOCATION OF SCHOOL ATTENDED

PERIOD OF ATTENDANCE

**(FOR EXAMPLE, OCTOBER 1983 TO MAY
1984)**

1sr Year

2nd Year

3rd Year

4th Year

I was graduated for the
day of

High School on the

I have, High School Diploma issued on

by the commissioner of education or the Superintendent of Public Instruction
of the State of Territory of

COLLEGE OR UNIVERSITY EDUCATION

NAME AND LOCATION OF SCHOOL ATTENDED

PERIOD OF ATTENDANCE

(FOR EXAMPLE, OCTOBER 1983 TO MAY 1984)

1sr Year

2nd Year

3rd Year

4th Year

I have credit for _____ of
(No. of Mayor, Semester-Hour or Clock Hours)
college work. I received the degree of
from _____ on the day of _____
(College or University)

(In addition to the above the applicant in required to furnish a transcript
from the college or university records with subjects and grades, to be sent
directly to the secretary of the board.)

EDUCATION IN PODIATRY MEDICINE

I attended _____ full courses lectures as
follows at _____
(NAME OF COLLEGE)

from the _____ day of _____ to the _____ day of _____
at _____
(NAME OF COLLEGE)

from the _____ day of _____ to the _____ day of _____
at _____
(NAME OF COLLEGE)

from the _____ day of _____ to the _____ day of _____
at _____
(NAME OF COLLEGE)

(In addition to the above applicant must have his record I.E., subjects and
grade, certified by the register of the college and sent directly to the
Secrtary of the Board.)

**CERTIFICATE OF GOOD MORAL CHARACTER OF APPLICANT FOR EXAMINATION
(SIGNED BY TWO LICENSED AND REGISTERED OR PODIATRIST IN GOOD STANDING)**

This certifies that I have been personally acquainted with
for _____ years, that I know
to be of good moral character, and hereby recommend
to the Board of Podiatry Medical Examiners of Puerto Rico as entirely
worthy of examination for a license to practice Podiatry Medicine of Puerto
Rico Pursuant to Law.

(SIGNATURE OF AFFIANT)

P.O. Address

_____ graduated (in the year _____)
of _____ License No. _____ by what state
issued? _____ (Physician signing must give number or his
license and name of state issuing same)

This certifies that I have been personally acquainted with
for _____ years, that I know
to be of good moral character, and hereby recommend
to the Board of Podiatry Medical Examiners of Puerto Rico as entirely
worthy of examination for a license to practice Podiatry Medicine of Puerto
Rico Pursuant to Law.

(SIGNATURE OF AFFIANT)

P.O. Address

_____ graduated (in the year _____)
of _____ License No. _____ by what state
issued? _____ (Physician signing must give number or his
license and name of state issuing same)

GRADES ACQUIRED IN THE EXAMINATION

(DATE OF EXAMINATION)

PART I

PART II

Pass

Fail

Pass

Fail

Name of Completed CPME approved Podiatric Medicine Program

Resident Director

Phone

Place and Address of previous Podiatric Medicine practice that you were actively involved for five uninterrupted years prior to this application (if applicable)

This application is approved for examination:

Date

President

Member

Member

This application has been rejected:

Date

President

Member

Member