

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

STATE OF NEW HAMPSHIRE

DIVISION OF HEALTH PROFESSIONS

Board of Podiatry

121 South Fruit Street, Suite 301

Concord, N.H. 03301-2412

Telephone 603-271-1203 · Fax 603-271-6702

PETER DANLES
Executive Director

JOSEPH G. SHOEMAKER
Division Director



INFORMATION REQUIRED ON APPLICATION FORM

1. Personal information must be completed in full by the applicant.
2. Certified copies of American/Foreign transcripts or diploma, which include podiatry education and certification of completion of internship/residency.
3. A certified copy of scores from national board examination, parts I, II and III must be submitted directly from the examining authority.
4. The Board also requires **TWO LETTERS OF REFERENCE, originals on professional letterhead**, from two licensed podiatrists who have known the applicant for at least one year and can attest to your moral and professional character and must state in what context or capacity the individual has known you. (Should not be provided by relative of the applicant.)
5. Clearances sent directly from all states where applicant holds or has ever held a license. Please use form attached to the application.
6. Curriculum Vitae is also required.
7. Photograph must accompany the application.
8. Signature of the applicant.
9. The application fee of \$300 must accompany the application. Please make check payable to **TREASURER, STATE OF NEW HAMPSHIRE**.

As soon as the completed application is received in this office, it will be acknowledged indicating whether it is complete or what requirements are missing.

Please do not make a firm commitment to start work on a certain date. Only applications which are complete, including all outside verifications, will be forwarded to the Board for review.

An application shall remain on current status for a period not to exceed 12 months.

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PODIATRY APPLICATION

APPLICATION FEE OF \$300

PAYABLE TO TREASURER, STATE OF
N.H. (NON-REFUNDABLE)

Name: _____
(Please print) Last First Middle Maiden

Residence Address: _____

City/State/Zip: _____

Home Phone Number: _____

Social Security Number: _____

Date of Birth: _____ Place of Birth: _____

Academic Education: _____ Year Graduated: _____
(Name and location of college-CERTIFIED COPY OF TRANSCRIPTS/DIPLOMA REQUIRED)

PLACE OF EMPLOYMENT:

Facility Name: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Extension: _____

PROPOSED PLACE OF EMPLOYMENT IN NEW HAMPSHIRE:

Facility Name: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Extension: _____

EXPERIENCE:

Employer	Address	Date of Employment To - From
_____	_____	_____
_____	_____	_____
_____	_____	_____

LICENSES:

States in which you currently hold or have ever held a registration/license:

_____ LIC. #: _____
_____ LIC. #: _____
_____ LIC. #: _____
_____ LIC. #: _____

(Clearances sent directly from all states is required. Please use form attached to the application)

DRUG ENFORCEMENT ADMINISTRATION NUMBER(S): Please provide DEA numbers for multi-site controlled substance storage:

DEA Number: _____ Site: _____

POST GRADUATE TRAINING: Please attach proof of one year of internship/residency training that meets the requirements of the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association. (Certified copy of certificate is acceptable.)

PERSONAL AFFIDAVIT: I have never been in an institution for treatment of insanity, drug addiction, or inebriety, except as follows:

I have never been arrested nor summoned into court as a defendant, nor indicted, nor convicted, nor fined, nor imprisoned, nor placed on probation, nor has any case against me been filed, nor have I ever forfeited collateral whatsoever, except as follows:

THIS IS A TRUE STATEMENT MADE UNDER THE PENALTIES OF PERJURY

Signature _____

PHOTO

(Print or type name & degree held)

(Present address)

Phone Number: () _____

PLEASE DO NOT WRITE BELOW THIS LINE

Date Application Received: _____ Date of Exam: _____

Application Fee Paid: _____ Date: _____

License #: _____ Date of Issue: _____

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**RESPONSIBILITY OF APPLICANT
STATE LICENSE CLEARANCE**

INSTRUCTIONS: The applicant who holds or has ever held a certification or license in another state must complete the personal information on this form and send the form to that licensing Board for completion.

TO THE LICENSING BOARD: The Podiatrist named below has applied for license in the State of New Hampshire. Please inform the N.H. Board of Podiatry of any pertinent information on this candidate which might affect the licensure process. All information is confidential.

PLEASE RETURN THIS FORM DIRECTLY TO THE NEW HAMPSHIRE BOARD OF PODIATRY, 121 SOUTH FRUIT STREET, CONCORD, NH 03301. THANK YOU.

Name: _____

Address: _____

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

State Certification or License Held _____

Certificate/License Number: _____ Expiration Date: _____

(FOR OUT-OF-STATE BOARD COMPLETION)

1. Name of Licensing Authority: _____

2. Full Name of Licensee: _____

3. License Number: _____

4. Is License Current? Yes No Expiration Date: _____

5. Is License Restricted? Yes No

6. Previous Disciplinary Action? Yes No

7. Pending Investigations? Yes No

If the answer is yes to questions 5, 6 or 7, please attach supporting information.

Please affix official
Board
seal here

Signature/Title

Date