

**NORTH CAROLINA BOARD OF PODIATRY EXAMINERS
CREDENTIALING APPLICATION
G.S. 90-202.2**

PLEASE COMPLETE AND SUBMIT SUPPORTING DOCUMENTATION WHERE APPLICABLE.

FOR OFFICE USE ONLY APPROVED FOR: ANKLE: _____ AMPUTATIONS: _____ CLUBFOOT: _____

NAME _____

ADDRESS _____

TELEPHONE _____

LICENSE NUMBER _____

- I. YEARS OF POST GRADUATE TRAINING:
- | | | | |
|----------|---------------------------|----------|-------------------------|
| _____ a. | 3 YEAR RESIDENCY | _____ a. | SURGICAL RESIDENCY |
| _____ b. | 2 YEAR RESIDENCY | _____ b. | ORTHOPAEDIC RESIDENCY |
| _____ c. | 1 YEAR RESIDENCY | _____ c. | PRIMARY CARE |
| _____ d. | PRECEPTORSHIP | _____ d. | ROTATING PODIATRIC RES. |
| _____ e. | OTHER | _____ e. | INTERNSHIP |
| _____ f. | NO POST GRADUATE TRAINING | _____ f. | SURGICAL PRECEPTORSHIP |
| | | _____ g. | OTHER |

HOSPITAL TRAINING INSTITUTION OR OTHER _____

YEARS IN WHICH TRAINING TOOK PLACE _____

- II. BOARD CERTIFICATION OR QUALIFICATION
ABPS – CERTIFIED, QUALIFIED OR ELIGIBLE – YEAR _____
ABPO – CERTIFIED, QUALIFIED OR ELIGIBLE – YEAR _____
ABPC – CERTIFIED, QUALIFIED OR ELIGIBLE – YEAR _____

III. FELLOW OR ASSOCIATE OF AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS
YEAR _____ YES _____ NO _____

IV. OTHER POSTGRADUATE EDUCATION, MINI RESIDENCIES, HANDS ON TRAINING, SEMINARS, WORKSHOPS, TRAINING WITH EXPERIENCED PHYSICIANS ETC. (LOCATIONS, DATES, ETC.) BE SPECIFIC AND COMPLETE.

- 1.
- 2.
- 3.
- 4.

USE ADDITIONAL PAPER IF NECESSARY

V. HOSPITAL AFFILIATION

NAME	TYPE OF PRIVILEGES	YEARS	SURGICAL/NON-SURGICAL
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- 1.
- 2.
- 3.
- 4.

VI. SURGERY CENTER AFFILIATIONS

NAME	TYPE OF PRIVILEGES	YEARS	SURGICAL/NON-SURGICAL
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- 1.
- 2.
- 3.
- 4.

VII. TEACHING APPOINTMENTS

NAME OF MEDICAL OR PODIATRY SCHOOL, YEARS OF AFFILIATION, TYPE OF APPT.

- 1.
- 2.
- 3.
- 4.

ACCORDING TO YOUR TRAINING AND ABILITY WHICH OF THE FOLLOWING ARE YOU QUALIFIED TO PERFORM:

- A. SURGERY OF THE ANKLE
- B. SURGICAL CORRECTION OF CLUBFEET
- C. AMPUTATIONS

THIS CREDENTIALING DOES NOT PRECLUDE THE CREDENTIALING OF INDIVIDUAL DOCTORS BY LICENSED HEALTHCARE FACILITIES IN NORTH CAROLINA.

SIGNATURE OF PODIATRIST CERTIFYING THAT
THE ABOVE INFORMATION IS TRUE AND ACCURATE

DATE