

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

*Please complete this form in DUPLICATE and send along with TWO COPIES of your surgery procedures logs—with Ankle Surgery, Amputations, and Clubfoot procedures HIGHLIGHTED in different colors-- to NC Board of Podiatry Examiners, 1500 Sunday Drive, Suite 102, Raleigh, NC 27607-515.*

If two copies are not received, your application will be returned. Questions: (919) 861-5583; [info@ncbpe.org](mailto:info@ncbpe.org)

FOR OFFICE USE ONLY

APPROVED FOR:

ANKLE: \_\_\_\_\_

AMPUTATIONS: \_\_\_\_\_

CLUBFOOT: \_\_\_\_\_

NAME \_\_\_\_\_

LICENSE NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TELEPHONE \_\_\_\_\_

**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
1.			
2.			
3.			
4.			

VI. SURGERY CENTER AFFILIATIONS

NAME	TYPE OF PRIVILEGES	YEARS	SURGICAL/NON-SURGICAL
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