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 HIGHTLIGHTED 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

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