

Montana Board of Medical Examiners
PO Box 200513
(301 South Park Avenue 4th Floor - Delivery)
Helena, MT 59620-0513
PHONE: (406) 444-5773 FAX: 406-841-2305
E-MAIL: dlibsmed@mt.gov WEBSITE: www.medicalboard.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

(PLEASE ALLOW A MINIMUM OF 10 DAYS FOR PROCESSING FROM THE DATE THE BOARD HAS A COMPLETE ROUTINE APPLICATION)

LICENSING REQUIREMENTS:

- ◆ Must be a graduate of a school of podiatry approved by the Board
- ◆ Must complete at least 1 year post-graduate training or have had equivalent experience or training approved by the Board (See Board Statute 37-6-302, MCA and rule ARM 24.156.1008)
- ◆ Must have passed an examination administered by the National Board of Podiatric Medical Examiners and be a diplomate of the National Board of Podiatric Medical Examiners
- ◆ Must be of good moral character

FEES: \$500.00 - Application Fee *Make payable to Montana Board of Medical Examiners*

DOCUMENTS: The following documents must be submitted to the Board office in order to complete your license application. The Board will accept paper or electronic versions.

- ◆ **Certification of Podiatry Education**
- ◆ **Copy of Board Certification**
- ◆ **Proof of 1 year post-graduate Training**
- ◆ **DD214, Military Discharge Paper**
- ◆ **Current Verification from all State Licensing Boards**
- ◆ **Verification of Examination Scores**
- ◆ **FPMB Disciplinary Report**

NOTE: ALL DOCUMENTS NOT IN ENGLISH MUST BE ACCOMPANIED BY CERTIFIED TRANSLATIONS.

ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE:

- ◆ **FEDERATION OF PODIATRIC MEDICAL BOARDS.** You may complete this form and submit the required fee and form to the address indicated or you may request a report from the FPMB through its website: www.fpmb.org. The results will be sent directly to the Board office. (This is to obtain the FPMB Disciplinary Report)

- ◆ **CERTIFICATE OF PODIATRY EDUCATION.** You must complete the bottom portion of page 8 in front of a notary and send the form to your podiatry school. The top portion of page 8 must be completed by school officials and sent directly back to the Board office.
- ◆ **VERIFICATION OF EXAMINATION SCORES.** You must request verification of your APMLE scores and have them sent directly to the Board office. For verification of Parts I and II, please contact Prometric at (877) 302-8952 or <http://apmle.com>. For verification of Part III (PMLexis) please contact the FPMB at (202) 810-3762 or www.fpmb.org or by writing to: Federation of Podiatric Medical Boards, 12116 Flag Harbor Drive, Germantown, MD 20874-1979.

APPLICATION PROCEDURES:

- ◆ When the application file is complete, it will be processed and considered by Board staff for permanent licensure. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.
- ◆ If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take 120 days to process.

Any application requiring Board review must be complete, with all materials received by the Department, no later than 15 working days in advance of the next scheduled Board meeting. Applications completed after that deadline will not be put on the Board's agenda.

- ◆ All verifications of licensure must be sent directly from each state board in which the applicant is currently or has ever been licensed. Please make copies of the attached verification request form as needed. Some states may charge a fee for verifications. Contact each state board prior to sending the request.
- ◆ Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES:

- ◆ An application file must be complete before consideration of licensure. The applicant will be notified in writing of any items missing from the application file.
- ◆ A routine application takes 10 days to process from the time it is complete.
- ◆ Once a routine application is processed and approved a permanent license will be issued.

For information with regard to the processing of this application, please contact the Board of Medical Examiners staff at (406) 444-5773 or email us at dlibsmed@mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR PODIATRY ON OUR WEBSITE: www.medicalboard.mt.gov

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Application for Licensure as Doctor of Podiatric Medicine

Allow 10 days from the date the Board has a complete routine application file for licensure.

1. FULL NAME _____
Last First Middle

2. OTHER NAME(S) KNOWN BY _____

3. BUSINESS NAME _____

4. BUSINESS ADDRESS _____
Street or PO Box # City and State Zip

5. HOME ADDRESS _____
Street or PO Box # City and State Zip

PREFERRED MAILING ADDRESS Business Home

6. E-MAIL ADDRESS _____

7. TELEPHONE (_____) _____ (_____) _____ (_____) _____
Business Home Fax

8. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____

9. DATE OF BIRTH _____ MALE
FEMALE

10. Which exam did you take for initial licensure?
NBPME PART I & II PART III (PMLexis) State Exam (indicate which state) _____

11. Do you intend to practice in the State of Montana? If yes, attach a brief explanation. Yes No

12. Have you ever previously applied for a license to practice in Montana? If yes, give date and results. Yes No

13. Have you ever been denied licensure or the opportunity to take this profession's licensing examination in any state or country? If yes, attach a detailed explanation. Yes No

14. Have you ever withdrawn an application for medical licensure? If yes, please give the state and reasons for withdrawal. Yes No

15. List all professional licenses you hold or **ever** have held. Verification must be sent directly to Montana from each state/province/territory.

State	License #	Issue Date	Expiration Date	License Method			Requested State Verification	
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No

16. Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
17. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
18. Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
19. Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
20. Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
21. Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. Yes No
22. Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupational license in anticipation of or during an investigation or disciplinary proceedings or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
23. Is there a pending complaint against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No
24. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare /Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

25. Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. Yes No
26. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. Yes No
27. Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a detailed explanation and provide documentation from the source. Yes No
28. Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. Yes No
29. Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purpose of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years and that resulted in fines of less than \$200; and (2) convictions prior to your 18th birthday unless you were tried as an adult. Yes No
30. Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. Yes No
31. Have you been diagnosed within the past 5 years with a physical condition or mental health disorder involving potential health risk to the public? If yes please provide a detailed explanation. Yes No
32. Have you ever been court-martialled or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation for the source. Yes No
33. Have you any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation. Yes No
34. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? If yes, attach a detailed explanation. Yes No

35. **PROFESSIONAL EDUCATION:**

Name of University or College	City and State/Province/Territory	Dates Attended	Degree Earned

Name of Podiatry School	City and State/Province/Territory	Dates Attended	Degree Earned

Post-graduate Program	City and State/Province/Territory	Dates Attended	Diploma Received
			Yes No
			Yes No

36. Have you ever been certified by a Podiatric Board? Yes No

Specialty/Certifying Board	Specialty	Date Awarded, Re-certified

Surgical Residency Program	City and State/Province/Territory	Dates Attended	Diploma Received
			Yes No
			Yes No

(Please note that if you wish to practice Ankle Surgery in the State of Montana, you will need to complete the Ankle Surgery Certification Application, submit additional fees and be approved by the Board.)

37. Have you ever been denied specialty certification or failed to pass a specialty certification examination or portion thereof? Yes No

By whom? _____

Reason for denial? _____ Number of times failed _____

38. PRACTICE HISTORY: List **all** activities after medical school (other than those already set forth above) in chronological order, up to and including the present. Specify nature of activity; for example, private practice, hospital practice, vacation, school, private employment, etc. (If medical practice, indicate nature of practice.) **Account for all periods of time longer than 1 month. Indicate specific month and year for each activity.** Use additional paper if necessary.

Name & Location of Practice	Activity/Position	Inclusive Dates	Reason for Leaving

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Legal Signature of Applicant

Date

CERTIFICATE OF PODIATRY EDUCATION

(Please forward this form to the school of podiatry for certification of applicant's podiatry degree)

Do not make this endorsement unless applicant has completed the AFFIDAVIT

Please complete and return form directly to: BOARD OF MEDICAL EXAMINERS, PO BOX 200513, HELENA, MT 59620-0513

It is hereby certified that _____ of

Graduated from _____ Location

Date Graduated _____, and is to the best of our knowledge is of good moral character.

President, Dean or Registrar Signature

Date Certified

(SEAL OF SCHOOL)

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice by anyone who might possess such information to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Legal Signature of Applicant

Dated

Subscribed and sworn to before me this _____ day of _____, _____ at

City/State

SEAL

Signature of Notary Public

Printed Name of Notary Public

For the State of

My commission expires _____.

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Please note: The following report can be ordered on the Federation of Podiatric Medical Boards' website, and the fees can be paid by credit card. If you do not wish to request the report online, please complete this form, enclose a check or money order (payable to the Federation of Podiatric Medical Boards) in the amount of \$75.00 and submit to:

**Federation of Podiatric Medical Boards
12116 Flag Harbor Drive
Germantown, MD 20874-1979**

Phone: 202-810-3762

Date: _____

The Montana Board of Medical Examiners requests a disciplinary search on me:

Name

Address

City, State, Zip

Date of Birth

Social Security Number

Medical School of Graduation and Location

Date of Graduation

Please mail the response directly to the Montana Board of Medical Examiners.

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A PHYSICIAN. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD: _____

I am applying for a license to practice medicine in the State of Montana. The Medical Board requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

(Signature) Name: _____ (Please print)

Address: _____

My License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS

State of _____:

Full Name of Licensee

License No. _____ Issue Date: _____ License is current? Yes No

If NO, please explain: _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? Yes No

If YES, explain and attach documentation _____

Has licensee ever been requested to appear before your Board? Yes No

If yes, explain: _____

Derogatory information, if any: _____

Comments, if any: _____

Signed: _____

Title: _____

State Board: _____ Date: _____

BOARD SEAL