

TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 - Austin, Texas 78711-2157 www.tdlr.texas.gov



RESIDENCY LICENSE APPLICATION INSTRUCTIONS

The following requirements <u>MUST</u> be submitted prior to issuance of a **RESIDENCY LICENSE** to practice podiatric medicine in Texas. A license will not be issued until <u>ALL</u> requirements are met. The practice of podiatric medicine without an appropriate license issued by the Texas Department of Licensing and Regulation (TDLR) is a criminal violation of Texas law.

To be eligible for a temporary residency license to practice podiatric medicine in Texas, you must have graduated from an approved college or school of podiatric medicine. A list of approved colleges/schools can be located on the **Council of Podiatric Medical Education's website**.

In addition, you MUST meet the following requirements and **SUBMIT** the appropriate documentation:

- 1. Complete application form.
- 2. Applicants must have passed the following American Podiatric Medical Licensing Examinations (APMLE): Part I, Part II Written and Part II CSPE. You must request official score reports from the <u>Federation of Podiatric Medical</u> <u>Boards (FPMB) website</u> and have them sent <u>directly</u> to TDLR.
 - For the 2015, 2017-2020 Classes, there are two components to the Part II examination: The Part II Written and the Part II CSPE. Persons from other classes are neither required nor eligible to take the Part II CSPE.
- 3. Submit information regarding residency program.
 - Memorandum of Understanding for Approved Residency Program. Complete form and return to TDLR.
 - Certificate of Acceptance for Postgraduate Training Program. Completed and signed by the residency director of the postgraduate training program that has accepted the applicant for residency training.
- CRIMINAL HISTORY Select if you have ever been convicted of, or placed on deferred adjudication for, any
 Misdemeanor or Felony, other than a minor traffic violation. If YES, complete and attach a <u>Criminal History</u>

 Questionnaire (PDF) for each offense.

If you are worried your criminal history could prevent you from getting this license, Texas allows you to have your criminal history evaluated before submitting your application and non-refundable fees. To request a criminal history evaluation, submit a <u>Criminal History Evaluation Letter (PDF)</u>, a completed <u>Criminal History Questionnaire</u> (<u>PDF</u>) for each crime you were convicted of, or placed on deferred adjudication for, and a \$10.00 fee.

REQUIRED FOR ALL NEW APPLICANTS:

Fingerprinting: All new applicants must submit fingerprints for a national criminal history record review. The applicant is responsible for paying the fee associated with this review to the fingerprint service vendor used by Texas Department of Public Safety. Once your completed application is received by TDLR, instructions on how to schedule an appointment to be fingerprinted will be emailed to you. Be sure your email address is current and legible to receive the fingerprinting information. To be eligible for licensing, you must successfully pass a criminal history background check.

- 5. Submit an official transcript verifying that your podiatric medical degree has been conferred or submit completed and signed Verification of DPM Degree form included with this application.
 - Official transcript. Submit official transcript from the podiatric medical school/college showing degree conferred to TDLR. Electronic university transcript(s) will be accepted if emailed to cs.transcript@tdlr.texas.gov from the university's secure site. We do not accept electronic transcripts from the applicant.
 - Verification of DPM Degree. The form must be completed by the podiatric school/college and returned directly to TDLR.

- 6. Proof of successfully completing a course in cardiopulmonary resuscitation (CPR). Provide a copy of a current CPR card or certification.
- 7. TDLR will conduct a query from the National Practitioner Data Bank (NPDB) for each applicant. A separate report is not required to be submitted to the Department.
- 8. <u>EMAIL ADDRESS</u> By providing my email address I authorize TDLR to send licensing communications and required notices to me by electronic mail. I understand that I may revoke this authorization in writing and that I must update my email address, or I will not receive these notices. I understand that the email address I have provided in this application will remain confidential except as permitted or required by law.
- SOCIAL SECURITY NUMBER Social Security number disclosure is required by Section 231.302(c)(1) of the
 Texas Family Code in order to obtain a license. Your social security number is subject to disclosure to an agency
 authorized to assist in the collection of child support payments. For more information regarding child support
 payments, contact the <u>Texas Attorney General</u>.

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

Texas Department of Licensing and Regulation P.O. Box 12157
Austin. TX 78711-2157

Documents submitted with your application will not be returned. Keep a copy of your completed application, all attachments, and your check or money order. Do not send cash.

For additional information and questions, visit the <u>TDLR website</u> or reach Customer Service via <u>webform</u>. The webform will allow you to submit your request for assistance and include attachments needed. Customer Service Representatives are available Monday through Friday (excluding holidays) at (800) 803-9202 (in state only), (512) 463-6599, or Relay Texas-TDD: (800) 735-2989.

TDLR Public Information Act Policy:

This document is subject to the Texas Public Information Act. With certain exceptions, information in this document may be made available to the public. For more information, view the **TDLR Public Information Act Policy**.



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RESIDENCY LICENSE APPLICATION

YOU MUST MEET ALL REQUIREMENTS WITHIN 12 MONTHS OF THE FILIN	NG DATE, OR THE APPLICATION WILL BE
TERMINATED	

	YOU MUST MEET ALL REQUIREMENTS WITHIN 12 MONTHS OF THE FILING DATE, OR THE APPLICATION WILL BE TERMINATED. APPLICATION FEE: \$125 (FEES ARE NON-REFUNDABLE)							
1.	1. Full Legal Name: (Name must be given in full, initials not acceptable)							
	Last			First			Middle	Suffix
2.	Other Names You Have Used	l:						
3.	Mailing Address:							
	Street Number and Name	or PO	Вох	Apt/Ste/Bldg	City		State	Zip Code
4.	Phone Number:		5.	Email Address:				
	(Area Code) Phone Number			(ex: johndoe@gma	ail.com) See Instruction	Sheet	for Disclosure Inforn	nation
6.	Social Security Number:			7. Date of Birth:		8.	Gender:	
	See Instruction Sheet for Disclosure Info	ormatio	า	Month/D	av/Year		Male	Female
	If You Have Ever Held a Texa			I	•			
ED	UCATION							
10.	List the name, address and atte	endan	ce in	formation for all unde	rgrad schools:		<u> </u>	A // 1
	Name		Address			From (Mo/Yr)	Attendance To (Mo/Yr)	
44	List name, address and attend	anaa i	oforn	action of all achaels	vhore professions	l mad	lietm, inetworte	n was ressived
11.	11. List name, address and attendance information of all schools where professional podiatry instruction was received to the school of Attendance information of all schools where professional podiatry instruction was received by the school of Attendance information of all schools where professional podiatry instruction was received by the school of Attendance information of all schools where professional podiatry instruction was received by the school of Attendance information of all schools where professional podiatry instruction was received by the school of Attendance information of all schools where professional podiatry instruction was received by the school of Attendance information of all schools where professional podiatry instruction was received by the school of Attendance information of all schools where professional podiatry instruction was received by the school of Attendance information of all schools where professional podiatry instruction was received by the school of Attendance in the school of Attendance							
	Name			Address	.		From (Mo/Yr)	To (Mo/Yr)
12. Doctor of Podiatric Medicine Degree granted by (submit official transcript showing degree conferred):								
		J	-	•	. 3	J	,	
Name of Podiatric Medical School			Address of School			Exact Date of Issuance		

- **13.** Applicants must have passed the following American Podiatric Medical Licensing Examinations (APMLE): Part I, Part II Written and Part II CSPE. You must request official score reports from the <u>Federation of Podiatric Medical Boards</u> (<u>FPMB</u>) <u>website</u> and have them sent <u>directly</u> to TDLR.
 - <u>For the Classes of 2015, 2017-2020,</u> there are two components to the Part II examination: The Part II Written and the Part II CSPE. Persons from other classes are neither required nor eligible to take the Part II CSPE.
- **14.** Applicants are required to be currently participating in a residency program or fellowship approved by the Council on Podiatric Medical Education.

Provide information below and submit a certificate of completion or letter from the residency director with start and end dates of residency program.

A.	Name of Residency or Sponsoring Institution (please list all surgical & non-surgical)	City, State	Type of Residency				Dates Attended (or Date to Complete)		
			PSR 12	PSR 24 or more	NON PSR	PM&S 24	PM&S 36	From	To
В .	Name of Fellowship or	City, State	Type of Followship Dates Att			ttended			
<u>В.</u>	Sponsoring Institution	Oity, State		Type of Fellowship				From	То

15. Have you been enrolled in another residency program in another state?

If YES, complete the information below.

Yes

No

State Name of Residency Program	Name of Residency Program	Dates of Enrollment			
	Name of Nesidency Frogram	From: (mm/dd/yy)	To: (mm/dd/yy)		

16. All applicants must have successfully completed a course in cardiopulmonary resuscitation (CPR). Provide a copy of a current CPR card or certification.

IF THE ANSWER TO ANY OF THE QUESTIONS BELOW (#'s 17-24) IS "YES," YOU MUST SUBMIT A FULL AND COMPLETE EXPLANATION. INCLUDE CERTIFIED COPIES OF ALL APPLICABLE COURT RECORDS AND/OR OTHER LEGAL DOCUMENTS, INCLUDING ALL STATEMENTS OF DISPOSITION, RELIEF FROM LIABILITIES, CERTIFICATION OF CONDUCT OR OTHER DOCUMENTS.

17. Have you been disciplined or charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. Military, U.S. Public Health Service or other U.S. Federal government entity and are awaiting final disposition by that body?

Yes No

If Yes, complete and submit the Disciplinary Action Questionnaire (PDF).

18. Have you ever been denied a license, had your license cancelled, suspended or revoked or permission to practice podiatric medicine or any other healing arts in any state, country, or U.S. federal jurisdiction?

Yes No

If Yes, complete and submit the **Disciplinary Action Questionnaire (PDF)**.

19. Have you ever had staff privileges in a hospital or other health care facility denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? If YES, please explain on a separate sheet of paper

Yes No

20. Has a claim or action for damages ever been filed against you in the course of practice of podiatric medicine or any other healing art which resulted in a malpractice settlement, judgment, or arbitration award of over \$70,000.00?

Yes No

If YES, please explain on a separate sheet of paper

21. Are you now, or were you in the past, addicted to or treated for addiction to chemical or controlled substances or have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If YES, please explain on a separate sheet of paper.	Yes	No
22. Have you ever been convicted of or pled no contest to a violation of any federal, state, or local law relating to the manufacture, distribution or dispensing of controlled substances, or to drug addiction? If YES, complete and submit the Criminal History Questionnaire (PDF).	Yes	No
23. Have you ever been convicted of, or pled no contest to any offense, misdemeanor or felony of any city, state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of \$500.00 or less). If YES, complete and submit the Criminal History Questionnaire (PDF).	Yes	No
Once your completed application is received, instructions on how to schedule an appointment to be finger emailed to you. Be sure your email address is current and legible to receive the fingerprinting information. See instructions sheet for more information.	•	е
YOU ARE REQUIRED TO LIST ANY CONVICTION INFORMATION PURSUANT TO SECTION 53.0 TEXAS OCCUPATIONS CODE OR UNDER ANY OTHER PROVISION OF LAW	21 & 202.25	3
24. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? If YES, please select the appropriate box(es) below:	Yes	No
A condition which required admission to an inpatient psychiatric treatment facility. Alcohol or chemical substance dependency or addiction. Emotional, mental or behavioral disorder. A physical disorder Other (explain):		
I, hereby certify under oath, that I am at least of age, and; that I am the person named in this application for a license to practice Podiatric Medicine in the and; that all statements herein are made as a basis of consideration for the Texas Department of Licensin to accept and consider as facts which concern my moral character, professional history and physical quarights and privileges of a license to practice Podiatric Medicine in the State of Texas, all of which are voluntarily pledge to refrain from dishonest or fraudulent methods in taking the examination and to refrainmoral or unprofessional conduct in my practice. I shall not by any method, or deceptive mean misrepresentations, misleading or untruthful statements to the public or my patients, or in my advertising, or cards, stationary, directories or any other medium. I hereby agree that the violation of this pledge, or any of the Podiatric Medical Practice Act of Texas (Section 202.253 and Section 202.501), the Penal Code of perjury) shall constitute sufficient cause for the denial, suspension, cancellation or revocation of the licentand I hereby authorize and grant the Texas Department of Licensing and Regulation the withdrawal of all rigaccrued to me thereunder. I authorize the release of any information or records held by any individual or a my training and qualifications as a Doctor of Podiatric Medicine upon request by the Department for use file.	ne State of Tog g and Regular alifications for true and cog in from unetled ans make used of the provice of the provice Texas (penates of the provice of the	exas, ation, or the orrect. hical, see of sional sions alty of o me, leges ive to
Signature of Applicant Da	ate	



MEMORANDUM OF UNDERSTANDING FOR APPROVED RESIDENCY PROGRAM

(Required for first year applicants only)

I, have accepted a residency with

. I am fully aware that the residency program

is an approved program with the Council of Podiatric Medical Education, thereby meeting the postgraduate training requirements for licensure in Texas.

I am further aware that after completing and filing a licensure application, I will be issued a Residency license by the Texas Department of Licensing and Regulation for practice only in the above-designated residency program. Should I leave the program at any time prior to the expiration date of the Residency license, I will upon that date of departure surrender my Residency license to the Texas Department of Licensing and Regulation. I am entering this program with the full knowledge that if I should not satisfactorily complete the program, no time spent in the postgraduate training program will be credited towards the Texas licensure requirement.

I certify under penalty of perjury under the laws of the State of Texas to the truth and accuracy of the above information.

Signature of Applicant Print Name Date



CERTIFICATE OF ACCEPTANCE FOR POSTGRADUATE TRAINING PROGRAM

IMPORTANT NOTICE: Completion of this form is required for licensure. This form must be completed and signed by the residency director of the postgraduate training program that has accepted the applicant for residency training.

	THIS FORM MUST BE SUBMITTED EACH YEAR BEFORE RESIDENCY LICENSE WILL BE ISSUED						
1.	Applicant Name:						
	Last	First	Middle	Suffix (Jr., Sr., III)			
2.	Applicant Date of Birth:	3. Applicant Social Sec	urity Number:				
	Month/Day/Year	See Instruction Sheet 1	or Disclosure Informa	ation			
4.	Applicant Address:						
	Street Number and Name or PO Box Apt/Ste/Bldg	City	State	Zip Code			
5.	Applicant Maiden or Given Surname:						
6	Residency Program Name:						
0.	Residency Frogram Name.						
7.	Beginning Date:	8. Ending Date:					
	Month/Day/Year Month/Day/Year						
9.	Business Address:						
	P.O. Box, Number, Street N						
10.	Business Telephone Number:	11. Home Telephone Nu	mber:				
	(Area Code) Phone Number (Area Code) Phone Number						
	I do hereby declare that the above-named applicant has been accepted for postgraduate training as indicated above.						
	Print Name of Residency Director	Signature of Residency Director					
	•	J	,				
	Title		Date				