Podiatrist Form 4PGY

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

CERTIFICATION OF APPROVED PODIATRIC POSTGRADUATE TRAINING

(To be used only for U.S. approved postgraduate podiatry training programs)

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your licensure application (Form 1). Be sure to sign and date item 8.
2. Send this form to the Director of Podiatric Medical Education of the hospital(s) in which you completed postgraduate training and ask that they complete Section II. Submit one form for each residency. You may photocopy this form as needed.
3. The hospital **must** send this form **directly** to the New York State Education Department. If the hospital in which you did your residency does not have a Director of Podiatric Medical Education, the form may be completed by the department chair. If the Education Department cannot determine that this verification came directly from the hospital, you will not receive credit for the postgraduate hospital training.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER

(Leave this blank if you do not have a U. S. Social Security Number)

2 BIRTH DATE

mo. day. yr.

3 PRINT YOUR FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)

Last

First

Middle

4 MAILING ADDRESS (You must notify the Department promptly of any name or address changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

5 TELEPHONE/E-MAIL ADDRESS

Daytime Phone

Area Code Phone Number

E-Mail Address (Please print clearly)

6 Print name under which postgraduate training was completed (if different from above): ____________________

7 Hospital in which postgraduate training was completed: ____________________

Address: ____________________

8 I request and give my permission to the hospital listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: ____________________ Date: _______ / _______ / _______
Mo. Day Yr.

SECTION II: CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL OFFICIAL: Please complete this section, sign the certifying statement, and return the form ***directly*** to the Office of the Professions at the address shown below. **This form will not be accepted if returned by the applicant.**

This is to certify that ____,
(Applicant's name see item 3, Section I)

a graduate of ____
(Podiatric Medical School)

was enrolled in a postgraduate training program(s) approved by the Council on Podiatric Medical Education at

____.
(Name and Location of Hospital)

Level of Training (example PGY-1)	Clinical Area	Inclusive Dates *(month, day, year)*	Successfully Completed
		____ / ____ / ____ to ____ / ____ / ____	❑ Yes ❑ No
		____ / ____ / ____ to ____ / ____ / ____	❑ Yes ❑ No
		____ / ____ / ____ to ____ / ____ / ____	❑ Yes ❑ No
		____ / ____ / ____ to ____ / ____ / ____	❑ Yes ❑ No
		____ / ____ / ____ to ____ / ____ / ____	❑ Yes ❑ No

CERTIFICATION

I am the director of podiatric medical education or department chair of the clinical area. I was the program director for the licensure applicant named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

If this licensure applicant did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

Signature of Podiatric Director/Chair: ______________________________ Date _____ / _____ / _____

Print or type name of Director/Chair: ______________________________

Title or official position: ______________________________

Institution: ______________________________

Address: ______________________________

____

Telephone number ____________________ Fax ____________________

E-mail ______________________________

RETURN DIRECTLY TO: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Podiatry Unit, 89 Washington Avenue, Albany, NY 12234-1000