



# UTAH DEPARTMENT OF COMMERCE

Division of Professional Licensing

## Podiatric Physician

### APPLICANT INFORMATION

Full Legal Name: \_\_\_\_\_  
First Middle Last

All Previous Legal Names: \_\_\_\_\_

Other DOPL Licenses Held: \_\_\_\_\_

SSN:\* \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female  
\* If you don't have a social security number, please follow the instructions on the last page.

Address: \_\_\_\_\_  
Street Address (including Apt/Unit/Ste #) and/or PO Box

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

*Note: All Division notices and communication will be sent to this email.*

Please select one:

- I am a United States citizen or a non-citizen of the United States who is lawfully present.
- I am a foreign national not physically present in the United States.
- None of the above, please explain: \_\_\_\_\_

Driver License or State ID Card: \_\_\_\_\_  
State of Issue License Number Expiration Date

**NOTE:** If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

### AFFIDAVIT AND RELEASE

I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, and discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.

I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Department of Commerce, State of Utah, any files, records, or information of any type reasonably required for the Department to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

I understand that I am responsible to update the Department of any changes relating to my application/license/certification/registration.

I understand that if the application is not complete at the time of submission, it will delay approval and could result in a denial.

**I declare under criminal penalty under the law of Utah that this application is true and correct.**

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_



QUALIFYING QUESTIONNAIRE

Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

1. [ ] Yes [ ] No Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise disciplined in any way?

2. [ ] Yes [ ] No Do you CURRENTLY have any criminal action active or pending?

3. [ ] Yes [ ] No WITHIN THE PAST 10 YEARS, have you pled guilty to, no contest to, entered into a plea in abeyance, or been convicted of a misdemeanor in any jurisdiction?

4. [ ] Yes [ ] No Have you EVER pled guilty to, no contest to, entered into a plea in abeyance, or been convicted of a felony in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
police report(s)
court record(s)
probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

Please DISCLOSE the following:

- charges that were later held in abeyance (plea in abeyance), diverted, reduced, or dismissed.
motor vehicle offenses such as driving while impaired or intoxicated.
if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).

You do NOT need to disclose:

- minor traffic offenses such as parking or speeding violations.
juvenile offenses, unless you were tried as an adult.
legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. (Use additional sheets if necessary.)

Profession: License Number:

Issuing State: License Status: Issue Date:

Profession: License Number:

Issuing State: License Status: Issue Date:

If you identified a Podiatric Physician (or equivalent) license above, please answer the following:

[ ] Yes [ ] No After obtaining the license(s) above, have you engaged in at least one year of experience in the state, district, or territory of the United States where the license was issued?

Note: If you answer yes to the question above, please see the checklist at the end of this application or our website for instructions on applying by endorsement.



**MEDICAL QUALIFYING QUESTIONNAIRE**

**Read thoroughly and answer each question. Do not leave any question blank.**

*A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.*

**1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:**

- Yes  No a hospital or health care facility
- Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
- Yes  No malpractice insurance coverage
- Yes  No other entity: \_\_\_\_\_

**2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:**

- Yes  No a hospital or health care facility
- Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- Yes  No The Federal Drug Enforcement Administration or any state drug enforcement agency
- Yes  No malpractice insurance coverage
- Yes  No other entity: \_\_\_\_\_

**3. Is any action pending against you now by:**

- Yes  No a hospital or health care facility
- Yes  No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- Yes  No the Federal Drug Enforcement Administration or any state drug enforcement agency
- Yes  No malpractice insurance coverage
- Yes  No other entity: \_\_\_\_\_

**4.  Yes  No Have you been named as a defendant in a malpractice suit?**

**5.  Yes  No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?**

If you answered "Yes" to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. NPDB website: <http://www.npdb.hrsa.gov>.

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

**NATIONAL PROVIDER IDENTIFIER (NPI)**

Your NPI: \_\_\_\_\_

**UTAH CONTROLLED SUBSTANCE AFFIDAVIT (OPTIONAL)**

*If you are applying for a controlled substance license, you must read and sign the affidavit below.*

1. I have reviewed and understand that I must abide by the additional laws and rules that govern the practice of my profession as it pertains to controlled substances.
2. I understand that there may be additional continuing education requirements for those who hold a controlled substance license.
3. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** *In addition to signing this affidavit, you must complete the items listed on the CONTROLLED SUBSTANCE LICENSE checklist at the end of this application to obtain a Controlled Substance License.*



Verification of Post-Graduate Training

Each supervisor must complete a separate form. The total of all forms must equal 24 months.

APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: First Middle Last

Address: City: State: Zip:

EMPLOYMENT INFORMATION (TO BE COMPLETED BY THE EVALUATING PHYSICIAN)

Evaluating Hospital/Institution:

Institution Address: Street Address (including Apt/Unit/Ste #) and/or PO Box

City: State: Zip:

Evaluating Physician: First Last License Number:

Phone: ( ) - Email:

Dates of Employment/Supervision: MM/DD/YYYY to MM/DD/YYYY

- Did the applicant successfully complete this training program?
Was the training program accredited by the Council on Podiatric Education?
Did the applicant ever take a leave of absence or break from their training?
Was the individual ever placed on probation?
Was the individual ever disciplined or placed under investigation?
Were any negative reports for behavioral reasons ever filed by instructors?
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?
Was the individual ever asked to leave a training or post-graduate program?

ATTESTATION:

I do hereby certify that the applicant for licensure as a licensed podiatric physician has successfully completed the above post-graduate residency program. I further certify that the applicant is qualified and competent to practice as a podiatric physician.

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature of Evaluating Physician: Date:



**APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)**

Full Legal Name: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**AFFIDAVIT OF UTAH RESIDENCY (OPTIONAL)**

*This section is only required for applicants who are requesting licensure prior to completing 24 months of progressive resident training.*

If you have not completed 24 months of post graduate training, you must have completed 12 months in an approved CPOME program and be currently enrolled in a progressive resident training program in Utah. Please list the program you are participating in:

Name of Program: \_\_\_\_\_ Date Began: \_\_\_\_\_

I certify that I have successfully completed 12 months of resident training in a CPOME approved program after receiving a degree of doctor of podiatric medicine. I am successfully participating in the CPOME progressive residency program listed above and have no disciplinary action. I agree to surrender my license to DOPL without any proceedings under Title 63G, Chapter 4, Administrative Procedures Act and DOPL will automatically revoke my license as a podiatric physician and surgeon if I fail to continue in good standing in the program identified.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

## APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.

**NOTE: Incomplete applications will be denied.**

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

**If you do not have a valid Social Security number**, you must submit your Individual Taxpayer Identification Number (ITIN), Alien Registration Number (A-number), or a copy of an unexpired government issued passport from your country of residence and an intent-to-hire letter from a Utah based employer ([Utah Code § R156-1-301](#)). Submission of the above documents may require additional documents to demonstrate lawful presence ([Utah Code § 63G-12-402 \(3\)\(k\)](#)).

### ALL APPLICANTS

All applicants are required to submit following items to complete the application:

- \$200.00 non-refundable application processing fee, made payable to "DOPL".
- Supporting documentation for any "yes" answers provided on either of the qualifying questionnaires.

### LICENSURE BY APPLICATION

In addition to the items required for all applicants, you must submit the following items:

- Official transcripts documenting completion of a podiatric program accredited by the Council of Podiatric Education.  
**Note:** Transcripts are considered "official" when they are sent directly from the school to DOPL or sealed in an envelope bearing the school's stamp/seal on the envelope flap.
- Verification of Post-Graduate Training (page 4 of this application). **Note:** Each supervisor must complete a separate form and the total of all forms must equal at least 24 months of post graduate training.
- Official score report from the National Board of Podiatric Medical Examiners verifying you have passed all components – Part I, Part II written, Part II CSPE, and Part III of the American Podiatric Medical Licensing Examination (APMLE).

**Note:** If you qualify for Licensure by Endorsement (see below), you do not need to submit the score report.

### LICENSURE BY ENDORSEMENT

If you are currently licensed in good standing as a podiatric physician in [a state, territory, or district of the United States deemed equivalent to a Utah license](#) and have at least one year of licensed experience, you may apply for **Licensure by Endorsement**. In addition to the items required by all applicants, you must submit the following:

- Official verification, showing active licensure in good standing for at least one year, from a jurisdiction designated by the Division as equivalent to Utah. Please see our website for additional information regarding approved states.  
**Note:** If your state is not deemed equivalent for purposes of endorsement, you may be able to use experience gained outside of the state to document the requirements for Initial Licensure above.

### OPTIONAL CONTROLLED SUBSTANCE LICENSE

If your practice in the state of Utah will include administering, possession or prescribing of controlled substances, you must apply for a Utah Controlled Substance License by submitting the following:

- \$100.00 non-refundable application processing fee, made payable to "DOPL".
- Complete the "Utah Controlled Substance Affidavit" found in this application.  
**Note:** In addition to the Utah Controlled Substance License, you must hold a valid Federal Drug Enforcement Administration (DEA) registration.

**Submit completed application to the Division:**

By US Postal Service:

Division of Professional Licensing  
PO BOX 146741  
Salt Lake City, UT 84114-6741

By in-person or express delivery:

Division of Professional Licensing  
Heber M Wells Building, 1st Floor  
160 E 300 S  
Salt Lake City, UT 84111

If you have questions, please contact the Division at 801-530-6628 or by email at [B1@Utah.gov](mailto:B1@Utah.gov).