

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION  
STATE OF NEW HAMPSHIRE  
**DIVISION OF HEALTH PROFESSIONS**  
**Board of Podiatry**  
7 Eagle Square  
Concord, N.H. 03301  
Telephone 603-271-1203 · Fax 603-271-6702

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**INFORMATION REQUIRED ON APPLICATION FORM**

1. Personal information must be completed in full by the applicant.
2. Certified copies of American/Foreign transcripts or diploma, which include podiatry education and certification of completion of internship/residency.
3. A certified copy of scores from national board examination, parts I, II and III must be submitted directly from the examining authority.
4. The Board also requires **TWO LETTERS OF REFERENCE, originals on professional letterhead**, from two licensed podiatrists who have known the applicant for at least one year and can attest to your moral and professional character and must state in what context or capacity the individual has known you. (Should not be provided by relative of the applicant.)
5. Clearances sent directly from all states where applicant holds or has ever held a license. Please use form attached to the application.
6. Curriculum Vitae is also required.
7. Photograph must accompany the application.
8. Signature of the applicant.
9. The application fee of \$300 must accompany the application. Please make check payable to **TREASURER, STATE OF NEW HAMPSHIRE**.

As soon as the completed application is received in this office, it will be acknowledged indicating whether it is complete or what requirements are missing.

Please do not make a firm commitment to start work on a certain date. Only applications which are complete, including all outside verifications, will be forwarded to the Board for review.

**An application shall remain on current status for a period not to exceed 12 months.**

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**PODIATRY APPLICATION**

**APPLICATION FEE OF \$300**

PAYABLE TO TREASURER, STATE OF  
N.H. (NON-REFUNDABLE)

Name: \_\_\_\_\_  
(Please print) Last First Middle Maiden

Residence Address: \_\_\_\_\_

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

Home Phone Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Academic Education: \_\_\_\_\_ Year Graduated: \_\_\_\_\_  
(Name and location of college-CERTIFIED COPY OF TRANSCRIPTS/DIPLOMA REQUIRED)

**PLACE OF EMPLOYMENT:**

Facility Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

**PROPOSED PLACE OF EMPLOYMENT IN NEW HAMPSHIRE:**

Facility Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

**EXPERIENCE:**

Employer	Address	Date of Employment To - From
_____	_____	_____
_____	_____	_____
_____	_____	_____

**LICENSES:**

States in which you currently hold or have ever held a registration/license:

\_\_\_\_\_ LIC. #: \_\_\_\_\_  
\_\_\_\_\_ LIC. #: \_\_\_\_\_  
\_\_\_\_\_ LIC. #: \_\_\_\_\_  
\_\_\_\_\_ LIC. #: \_\_\_\_\_

(Clearances sent directly from all states is required. Please use form attached to the application)

**DRUG ENFORCEMENT ADMINISTRATION NUMBER(S):** Please provide DEA numbers for multi-site controlled substance storage:

DEA Number: \_\_\_\_\_ Site: \_\_\_\_\_  
\_\_\_\_\_

**POST GRADUATE TRAINING:** Please attach proof of one year of internship/residency training that meets the requirements of the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association. (Certified copy of certificate is acceptable.)

**PERSONAL AFFIDAVIT:** I have never been in an institution for treatment of insanity, drug addiction, or inebriety, except as follows:

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I have never been arrested nor summoned into court as a defendant, nor indicted, nor convicted, nor fined, nor imprisoned, nor placed on probation, nor has any case against me been filed, nor have I ever forfeited collateral whatsoever, except as follows:

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THIS IS A TRUE STATEMENT MADE UNDER THE PENALTIES OF PERJURY

Signature\_\_\_\_\_

**PHOTO**

\_\_\_\_\_  
(Print or type name & degree held)

\_\_\_\_\_  
(Present address)

Phone Number: (\_\_\_\_)\_\_\_\_\_

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**PLEASE DO NOT WRITE BELOW THIS LINE**

Date Application Received:\_\_\_\_\_ Date of Exam:\_\_\_\_\_

Application Fee Paid:\_\_\_\_\_ Date:\_\_\_\_\_

**License #:**\_\_\_\_\_ **Date of Issue:**\_\_\_\_\_

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**RESPONSIBILITY OF APPLICANT  
STATE LICENSE CLEARANCE**

**INSTRUCTIONS:** The applicant who holds or has ever held a certification or license in another state must complete the personal information on this form and send the form to that licensing Board for completion.  
**TO THE LICENSING BOARD:** The Podiatrist named below has applied for license in the State of New Hampshire. Please inform the N.H. Board of Podiatry of any pertinent information on this candidate which might affect the licensure process. All information is confidential.

PLEASE RETURN THIS FORM DIRECTLY TO THE NEW HAMPSHIRE BOARD OF PODIATRY, 7 EAGLE SQUARE, CONCORD, NH 03301. THANK YOU.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

State Certification or License Held \_\_\_\_\_

Certificate/License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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**(FOR OUT-OF-STATE BOARD COMPLETION)**

1. Name of Licensing Authority: \_\_\_\_\_
2. Full Name of Licensee: \_\_\_\_\_
3. License Number: \_\_\_\_\_
4. Is License Current?      Yes              No      Expiration Date: \_\_\_\_\_
5. Is License Restricted?      Yes              No
6. Previous Disciplinary Action?      Yes              No
7. Pending Investigations?      Yes              No

**If the answer is yes to questions 5, 6 or 7, please attach supporting information.**

Please affix official  
Board  
seal here

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date