STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
Medical Board of California
BOARD OF PODIATRIC MEDICINE
1420 Howe Avenue, Suite 8, Sacramento, CA. 95825-3229
P (916) 263-2647 F (916) 263-2651 www.bpm.ca.gov

APPLICATION FOR A CERTIFICATE TO PRACTICE PODIATRIC MEDICINE

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

❍ BPM use only

1. Name: *Last* *First* *Middle*

2. Other names you have used:

3. Social Security Number (See disclosure statement on Form **P1C**)
– –

4. Address: *Number and Street/Rural Route (include apartment number, if any).*

City *State* *Zip Code* *Country*

5. Telephone Number: *Home* ( ) - *Area Code* *Work* ( ) - *Area Code*

6. Date of Birth: *mm/dd/yy* / /

7. Sex: ❍ Female ❍ Male

8. Are you a U.S. citizen? ❍ Yes ❍ No ❍

9. Have you ever filed an application for licensure in California? ❍ Yes ❍ No ❍
If YES, give date of previous application: / /

10. List name and address of all colleges or universities attended other than schools where professional podiatry instruction was received.

Name	*Address*	*Period of Attendance*		
		From (Mo/Yr)	*To (Mo/Yr)*	
		/	/	❍
		/	/	❍
		/	/	❍

11. List names and address of all schools where professional podiatry instruction was received. Submit an original Certificate of Podiatric Medical Education (Form **P2**) and official transcripts from each school attended.

Name	*Address*	*Period of Attendance*		
		From (Mo/Yr)	*To (Mo/Yr)*	
		/	/	❍
		/	/	❍
		/	/	❍

12. Doctor of Podiatric Medicine Degree granted by:

Name of Podiatric Medical School *Address of School* *Exact Date of Issuance*