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**State of Rhode Island
Board of Podiatric Medicine**

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

**Licensure as a
Limited Podiatrist**

Applicant - Print Name (First/MI/Last)

Phone: (401) 222-2828

TTY/TDD: (800) 745-5555

Fax: (401) 222-1272

Revised 04/22/2009 jcp

GENERAL INFORMATION

Enclosures

The following materials and information are enclosed with this application packet:
Instructions for Completing Board Application

Application Materials:

- Board Application
- Application Checklist
- Mandatory Social Security Number Verification

Licensure Requirements

1. License Fee of **(\$70.00 (\$140.00 with CSR))** (Check or Money Order ONLY - Payable to RI General Treasurer).
2. Good moral character;
3. 18 years of age or older;
4. Completed not less than two (2) years of study in an accredited podiatry school; and
5. Appointment as an intern, resident, fellow or podiatry officer;

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the BOARD application. Only complete applications will be accepted. Failure to submit all required information may result in processing delays. All of the information provided is subject to change.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type the information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. It is suggested that a copy be made of the completed application before submitting it to the Board.
5. Incomplete applications will be returned unprocessed.
6. It is the applicant's responsibility to check on the status of the application.

Complete all application materials as instructed and arrange them in the order as they appear in the application checklist. Attach all documents to the BOARD application, along with the check or money order, and mail to the following address:

Rhode Island Department of Health
Board of Podiatric Medicine
Room 104, 3 Capitol Hill
Providence, RI 02908-5097

To view a copy of the Rules and Regulations please visit our website at:

<http://www.health.ri.gov/hsr/professions/podiat.php>

HEALTH will not, for any reason, accelerate processing of one applicant at the expense of other applicants. Once completed, the application will be reviewed, and you will be contacted in writing. Be advised, you may be required to appear for an interview.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of the BOARD application, please contact the BOARD at (401) 222-2828.

7. Preferred Mailing Address

Please check ONE

Please use my Home Address as my preferred mailing address

Please use my Business Address as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license..

Type of School (High School, University, College, Trade/Technical School etc.)

Type of School (High School, University, College, Trade/Technical School etc.)

Name of School

Name of School

Date Graduated: State Month Day Year

Date Graduated:

State

Month

Day

Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

Is school accredited by the Council of Podiatric Medical Education of the American Podiatry Association?

Yes No

9. Affidavit of Superintendent or Administrator of the Hospital

To be signed by the hospital administrator or superintendent of the hospital in which the applicant has received an appointment

I hereby certify that the applicant: Name of Applicant

Is a Limited Podiatrist and will receive training as required.

Date Hired (as a Limited Podiatrist) Month Day Year

Hospital Name:

Name (Printed) of Hospital Official

Signature:

Date Signed Month Day Year

NOTE: Your application will be returned to you if this section is not completed.

10. Affidavit of Dean of the Podiatry School

To be signed by the dean of the podiatry school.

I hereby certify that the applicant: Name of Applicant

has creditably completed not less than two (2) years of study in

Name of Podiatry School

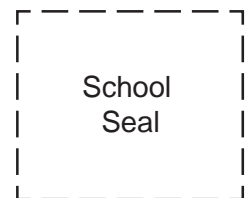
From: Month Day Year To: Month Day Year

Name (Printed) of Dean

Signature:

Date Signed: Month Day Year

NOTE: Your application will be returned to you if this section is not completed.



14. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Podiatric Medicine any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as Limited Podiatrist in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Podiatric Medicine of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

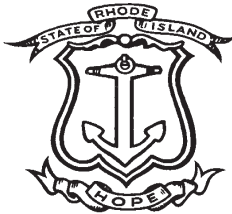
Name of Notary (Print, Type or Stamp)

Signature of Notary

Notary Seal

Notary No/Commission No.

Commission Expiration Date (MM/DD/YY)



Rhode Island Department of Health
3 Capitol Hill, Providence RI , 02908-5097
Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. . These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

- I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.
- I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.
- I am currently pursuing administrative review of taxes owed to the state.
- I am in federal bankruptcy. (Case # _____)
- I am in state receivership. (Case # _____)
- I have been discharged from bankruptcy. (Case # _____)

Type of Professional License for which you are applying.

Full Name (Please Print or Type)

Social Security Number

Signature

Phone Number (including area code if not 401)

Date

This form must be completed, signed and attached to your license application for processing.



IF Applying for CSR, this Application **MUST BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION.**

Substitute forms are not acceptable

Rhode Island Board of Podiatry

Room 104 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniform Controlled Substances Act Registration (CSR). I understand that there is an additional \$140.00 fee for this Registration and that the check or money order must be made out to the "RI General Treasurer".

Print/Type Full Name _____	Rhode Island Business Name _____	
Signature _____	Rhode Island Business Address _____	Business Telephone _____
Date _____	Business Fax _____	

<p>Complete this application for registration to prescribe controlled substances in the State of Rhode Island</p>	<p>The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site: http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm</p> <p style="text-align: center;">Drug Schedule (Check all that apply)</p> <p><input type="checkbox"/> Schedule II <input type="checkbox"/> Schedule III <input type="checkbox"/> Schedule IV <input type="checkbox"/> Schedule V</p>
<p>A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.</p> <p>The CSR is renewed at the same time that the professional license is renewed.</p> <p>NOTE: Read Important Information on the bottom of this application.</p>	<p>A Copy of the DEA Registration must be provided to the Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.* All Applicants MUST answer the following:</p> <p>A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">If you answered "Yes" to question "A" or "B" attach an explanation to this form.</p>

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "VOID". Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location:
Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV and V cannot be written for more that one hundred (100) dosage units and not more than one hundred (100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.