Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
Fax #: (608) 251-3036
Phone #: (608) 266-2112

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

PODIATRY AFFILIATED CREDENTIALING BOARD
CERTIFICATE OF POSTGRADUATE TRAINING

APPLICANT: Complete application number (above) and boxed section immediately below and submit to program for completion. Form must be returned directly from the postgraduate training program to the Department.

Applicant Name	**Application Number**

Name of Hospital

Address of Hospital (number/street)	(city)	(state)	(zip code)

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

Applicant Signature (If unable to provide a digital signature, print and sign form.)	**Date** (mm/dd/yyyy)
	____/____/__________

TRAINING PROGRAM: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

1. In what type and level(s) of training did this podiatrist participate at your facility? Indicate below each level of training in which the above-named Physician participated in your program. Provide start/end dates, type of training, and whether credit was given for the training.

DATES OF TRAINING (month/day/year)	TYPE OF SPECIALTY TRAINING	FULL CREDIT	PARTIAL CREDIT
PGY 1: **From** ____/____/______ **To** ____/____/______		Yes ☐ No ☐	Yes ☐ No ☐
PGY 2: **From** ____/____/______ **To** ____/____/______		Yes ☐ No ☐	Yes ☐ No ☐
PGY 3: **From** ____/____/______ **To** ____/____/______		Yes ☐ No ☐	Yes ☐ No ☐

2.	Was the residency accredited by Council of Podiatric Medical Education (CPME)?	Yes ☐ No ☐
3.	Did the podiatrist complete the full training program in good standing? **If no, please attach explanation on a separate sheet.**	Yes ☐ No ☐
4.	Was the podiatrist asked to or required to repeat any portion of the training at your facility? **If yes, please attach explanation on a separate sheet.**	Yes ☐ No ☐

Continued on next page.

Wisconsin Department of Safety and Professional Services

Training program completion, continued.

If you answer Yes to questions 5-14, attach an explanation on a separate sheet.

5.	Was the podiatrist placed on probation, suspended or in any way sanctioned/disciplined while at your facility? **If yes, please attach explanation on a separate sheet.**	Yes ☐ No ☐
6.	Was this podiatrist granted a leave of absence while training at your facility? **If yes, please attach explanation on a separate sheet.**	Yes ☐ No ☐
7.	Did this individual have a record of unexcused absences during his/her attendance at this training program? **If yes, please attach explanation on a separate sheet.**	Yes ☐ No ☐
8.	Were any restrictions and/or special requirements placed on this podiatrist's activities that were not placed on all other residents at his/her level of training? **If yes, please attach explanation on a separate sheet.**	Yes ☐ No ☐
9.	Were any formal patient or staff complaints filed against this podiatrist? **If yes, please attach explanation on a separate sheet.**	Yes ☐ No ☐
10.	Were any incident reports filed involving the professional behavior or conduct of this podiatrist? **If yes, please attach explanation on a separate sheet.**	Yes ☐ No ☐
11.	Was this podiatrist ever subject to non-routine monitoring while at your facility? **If yes, please attach explanation on a separate sheet.**	Yes ☐ No ☐
12.	Were any malpractice actions filed naming this podiatrist as a defendant that involved his/her period of training at your facility? **If yes, please attach explanation on a separate sheet.**	Yes ☐ No ☐
13.	Is there any additional information in this podiatrist's file that would assist the Board in determining this applicant's eligibility for licensure. **If yes, please attach explanation on a separate sheet.**	Yes ☐ No ☐

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature of Program Director (If unable to provide a digital signature, print and sign form.)	**Date** (mm/dd/yyyy)
	____/____/__________
Printed Name of Program Director	**Phone**
Title	

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