STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

PODIATRIC RESIDENCY VERIFICATION FORM

TO BE COMPLETED BY APPLICANT

Applicant: Enter your full name and birth date on this form and forward it to the Program Administrator for completion. This form must be completed by the current program administrator and returned directly to this office.

Applicant's Name Danielle Butts Date of Birth 10-2-1985

TO BE COMPLETED BY PROGRAM DIRECTOR ONLY

Dear Administrator: Please provide the following verification of residency training for the above-named Connecticut Podiatrist.

Name and location of facility/institution where residency training was completed:
Saint Francis Hospital and Medical Center – 114 Woodland Street, Hartford, CT 06105

Dates of training: from 07 / 01 / 2012 to: 06 / 30 / 2015

At the time of the applicant's completion of the residency training program, was the training program accredited by the Council on Podiatric Medical Education? YES ☑ NO ☐.

Did the applicant satisfactorily complete this period of residency training? YES ☑ NO ☐.

Do you have any derogatory information regarding the competency or conduct of this applicant? YES ☑ NO ☐. **If yes,** please attach any disclosable documents you may have on file regarding such information.

I, Rafael Gonazalez, D.P.M., do certify that I am the Program Administrator at Saint Francis Hospital and Medical Center, and that the information provided herein is true and correct to the best of my knowledge and belief.

Signature of Program Administrator Date: June 6, 2016

(860) 714-5911
Telephone number Email: rafaleares@gmail.com

Please complete and return directly to:
Department of Public Health
Podiatric Ankle Surgery Permit
410 Capitol Ave., MS# 12APP
P.O. Box 340308
Hartford, CT 06134
Fax: (860) 509-8457