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 _____ Date of Birth _____

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:

_____

Dates of training: from _____ / _____ / _____ to: _____ / _____ / _____

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, _____, do certify that I am the Program Administrator

at _____, and that the information provided herein

is true and correct to the best of my knowledge and belief.

_____ Date: _____
Signature of Program Administrator

_____ Email: _____
Telephone number

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