TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157

www.tdlr.texas.gov

DOCTOR OF PODIATRIC MEDICINE LICENSE APPLICATION INSTRUCTIONS

To be eligible for a DPM license to practice podiatric medicine in Texas, you must have graduated from an approved college or school of podiatric medicine. A list of approved colleges/schools can be located on the Council on ***Podiatric Medical Education's website***. TDLR will conduct a query from the National Practitioner Data Bank (NPDB) for each applicant. A separate NPDB self-query report is not required to be submitted by the applicant to the Department.

NOTICE: DPM applicants who are currently enrolled in their (final) third (3) year of residency may not apply until on or after March 1st.

DOCUMENTS SUBMITTED WITH YOUR APPLICATION WILL NOT BE RETURNED. KEEP A COPY OF YOUR COMPLETED APPLICATION, ALL ATTACHMENTS, AND YOUR CHECK OR MONEY ORDER.

1. NAME – Print your legal name in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
2. OTHER NAMES USED – Provide other names you have used in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and II. (Mr. is not a suffix.)
3. GENDER – Select whether you are male or female.
4. DATE OF BIRTH – Provide your birthdate.
5. SOCIAL SECURITY NUMBER – Social Security number disclosure is required by Section 231.302(c)(1) of the Texas Family Code in order to obtain a license. Your social security number is subject to disclosure to an agency authorized to assist in the collection of child support payments. For more information regarding child support payments, contact the ***Texas Attorney General*** or call (512) 460-6000 or (800) 252-8014.
6. EMAIL ADDRESS – Provide your email address only if you agree to the following statement. By providing my email address I authorize the Texas Department of Licensing and Regulation (TDLR) to send licensing communications and required notices to me by electronic mail. I understand that I may revoke this authorization in writing and that I must update my email address, or I will not receive these notices. I understand that the email address I have provided in this application will remain confidential except as permitted or required by law.
7. PHONE NUMBER – Provide a telephone number, including the area code, where we can reach you during the day. This may be your office phone number where we can leave a message.
8. MAILING ADDRESS – Provide your current mailing address. This is the address where we will send you mail. This address can be a post office box. You can add the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
9. PREVIOUS TEXAS DOCTOR OF PODIATRIC MEDICINE LICENSE – Provide previous Texas DPM license type and license number.
10. EDUCATION INFORMATION – List the institution, location, and period of attendance.
11. SCHOOLS WHERE PROFESSIONAL PODIATRY INSTRUCTION WAS RECEIVED – List the institution, location and period of attendance.
12. DOCTOR OF PODIATRIC MEDICINE DEGREE **–** List the name, address, exact date your DPM degree was issued and submission of official transcript showing degree conferred.
13. AMERICAN PODIATRIC MEDICAL LICENSING EXAMINATION (APMLE) – Formerly known as the National Board of Podiatric Medical Examiners (NBPME) examinations, applicants must have passed the following required ***APMLE*** examinations. You must request official score reports from the Federation of Podiatric Medical Boards (FPMB) and have them sent **directly** to TDLR from the ***FPMB website***.

- National Boards – Part I
- National Boards – Part II Written
- National Boards – Part II CSPE
- Beginning with the Class of 2015 (excluding the Class of 2016 and 2021) there are two components to the Part II examination: The Part II Written and the Part II CSPE. Persons from earlier classes are neither required nor eligible to take the Part II CSPE."
- National Boards – Part III (formerly known as PM Lexis) Applicants who were licensed in another state prior to January 1992 may request an exemption from the Part III requirement.

14. RESIDENCY CERTIFICATE OF COMPLETION – Applicants must submit a copy of your Residency Certificate of Completion or Fellowship Completion approved by the Council on Podiatric Medical Education or letter from the residency director with start and end dates of the residency program. Applicants who are currently enrolled in their (final) third (3) year of residency must submit the Memorandum of Understanding for Conditional Issuance of Texas Doctor of Podiatric Medicine License.
15. PRACTICE OF PODIATRIC MEDICINE IN ANOTHER STATE – Submit license verification from all states in which a podiatric medical license has been held. (Current, temporary, cancelled, etc.)
    - **Certificate by Licensing Agency.** Forward to licensing agencies for any state or country in which you have held a podiatric medical license (i.e., Temporary, Provisional, Permanent, etc.). The form must be completed by each licensing agency and returned **directly** to TDLR.
16. CERTIFICATION OF CARDIOPULMONARY RESUSCITATION (CPR) – Proof of successfully completing a course in cardiopulmonary resuscitation (CPR). Provide a copy of a current CPR card or certification.
17. UNPROFESSIONAL CONDUCT – If you answer Yes, you must submit a full and complete ***Disciplinary Action Questionnaire (PDF)*** with an explanation and certified copies of all applicable court records and/or other legal documents, including all statements of dispositions, relief from disabilities, certification of conduct or other documents.
18. DISCIPLINARY ACTION HISTORY (DAQ) – Indicate if you have ever had a professional license, certification, or registration suspended, canceled, revoked, or denied in any state. If you have, complete and attach a ***Disciplinary Action Questionnaire (PDF)*** for each disciplinary action.
19. STAFF PRIVILEGES IN A HOSPITAL OR HEALTH CARE FACILITY – Have you ever had staff privileges in a hospital or other health care facility denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?If Yes, please explain on a separate sheet of paper.
20. CLAIM OR ACTION FILED AGAINST YOU – Has a claim or action for damages ever been filed against you for practicing podiatric medicine or any other healing art which resulted in a malpractice settlement, judgment, or arbitration award of over $70,000.00? If Yes, please explain on a separate sheet of paper.
21. ADDICTED OR TREATED FOR ADDICTION TO A CONTROLLED SUBSTANCE – Are you now, or were you in the past, addicted to or treated for addiction to chemical or controlled substances, such as narcotics or alcohol or other substances? If Yes, please explain on a separate sheet of paper.

22-23. CRIMINAL HISTORY QUESTIONNAIRE (CHQ) – Indicate if you have ever been convicted of, or placed on deferred adjudication for, any Misdemeanor or Felony, other than a minor traffic violation. If YES, complete and attach a ***Criminal History Questionnaire (PDF)*** for each offense. If you are worried your criminal history could prevent you from getting this license, Texas allows you to have your criminal history evaluated before submitting your application and non-refundable fees. To request a criminal history evaluation, submit a ***Criminal History Evaluation Letter (PDF)***, a completed ***Criminal History Questionnaire (PDF)*** for each crime you were convicted of, or placed on deferred adjudication for, and a $10.00 fee.

REQUIRED FOR ALL NEW APPLICANTS: Fingerprinting: All new applicants must submit fingerprints for a national criminal history record review. The applicant is responsible for paying the fee associated with this review to the fingerprint service vendor used by the Texas Department of Public Safety. Once your completed application is received by TDLR, instructions on how to schedule an appointment to be fingerprinted will be emailed to you. Be sure your email address is current and legible to receive the fingerprinting information. To be eligible for licensing, you must successfully pass a criminal history background check.

24. IMPAIRMENT OR LIMITATIONS TO PRACTICE PODIATRIC MEDICINE – Do you have any condition which in any way impairs or limits your ability to practice podiatric medicine with reasonable skill and safety, including but not limited to a condition which required admission to an inpatient psychiatric treatment facility, alcohol or chemical substance dependency or addiction, emotional, mental or behavioral disorder, a physical disorder or any other condition that would limit or impair your ability to practice podiatric medicine.

25. APPLICANT'S AFFIMRATION – Carefully read the statement before dating and signing your application.

APPLICATION INFORMATION FOR MILITARY SERVICE MEMBERS, MILITARY VETERANS AND MILITARY SPOUSES
The Texas Department of Licensing and Regulation recognizes the contributions of our active duty military service members, their spouses, and veterans. If you want to use one of the licensing options available to military service members, military veterans and military spouses, please complete the ***Military Service Member, Military Veteran or Military Spouse Supplemental Application (PDF)*** and attach it with your license application. If you have additional questions about qualifications, training or experience requirements relating to occupational licensing for military service members, military veterans or military spouses please go to the ***TDLR Military Information web page***.

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

TDLR
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your application will not be returned. Keep a copy of your completed application, all attachments, and you check or money order. Do not send cash. For additional information and questions, please visit the ***TDLR website***.

You may request assistance or submit required attachments via ***TDLR webform*** or Fax (512) 475-2871. You may contact Customer Service Representatives by calling (800) 803-9202 [in state only], or (512) 463-6599; Relay Texas - TDD: (800) 735-2989. Customer Service Representatives are available Monday through Friday 7:00 a.m. until 6:00 p.m. Central Time (excluding holidays).

TDLR Public Information Act Policy:
This document is subject to the Texas Public Information Act. With certain exceptions, information in this document may be made available to the public. For more information, view the ***TDLR Public Information Act Policy***.

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DOCTOR OF PODIATRIC MEDICINE LICENSE APPLICATION

APPLICATION FEE: $750.00 (FEE IS NON-REFUNDABLE)

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.

1. Name:

Last, First, Middle Name, Suffix (Jr., Sr., III)

2. Other Names You Have Used:

Last, First, Middle Name

3. Gender: ☐ Male ☐ Female

4. Date of Birth: Month/Day/Year

5. Social Security Number

See Instruction Sheet for Disclosure Information

6. Email Address:

(ex: johndoe@gmail.com) See Instruction Sheet for Disclosure Information

7. Phone Number

(Area Code) Phone Number

8. Mailing Address:

P.O. Box, Number, Street Name/Apartment Number City State Zip Code

9. If you have ever held a Texas DPM license list type and license #: _____

10. Educational Information: List the Name, address and attendance information for all undergraduate schools.

- Institutional Name: _____
- Location: (Address, City, State, Zip Code) _____
- Period Attended Begin: (Mo/Yr) _____ End: (Mo/Yr) _____

- Institutional Name: _____
- Location: (Address, City, State, Zip Code) _____
- Period Attended Begin: (Mo/Yr) _____ End: (Mo/Yr) _____

- Institutional Name: _____
- Location: (Address, City, State, Zip Code) _____
- Period Attended Begin: (Mo/Yr) _____ End: (Mo/Yr) _____

11. List the name, address and attendance information of all colleges/schools where professional podiatry instruction was received.

- Institutional Name: _____
- Location: (Address, City, State, Zip Code) _____
- Period Attended Begin: (Mo/Yr) _____ End: (Mo/Yr) _____

12. Doctor of Podiatric Medicine Degree granted by: (Have conferred DPM transcript sent directly to TDLR from the University)

- Institutional Name: _____
- Location: (Address, City, State, Zip Code) _____
- Exact Date of Issuance: _____

13. Formerly known as the National Board of Podiatric Medical Examiners (NBPME) examinations, applicants must have passed the required APMLE examinations. You must request official score reports from the Federation of Podiatric Medical Boards (FPMB) and have them sent directly to TDLR from the FPMB.

Requesting Scores by Mail at:
Federation of Podiatric Medical Boards 12116 Flag Harbor Drive
Germantown, MD 20874-1979 Phone: (202) 810-3762

Scores may also be ordered online at:
www.fpmb.org

14. You must have completed or be currently participating in your (final) third (3) year of a residency program or fellowship approved by the Council on Podiatric Medical Education. You must submit a copy of your Residency Certificate of Completion or Fellowship Completion approved by the Council on Podiatric Medical Education or letter from the residency director with start and end dates of the residency program.

15. Have you ever been licensed to practice podiatric medicine in another state? ☐ Yes ☐ No

If YES, list all states in which you are currently or were previously licensed. Include license number, date issued and dates of practice for each. Each licensing agency in which you are licensed or have been licensed must complete the Certificate by Licensing Agency form and submit to TDLR.

State	License Number	Date of Issuance	Dates of Practice	
			From: (mm/dd/yyyy)	To: (mm/dd/yyyy)

16. All applicants must have successfully completed a course in cardiopulmonary resuscitation (CPR). Provide a copy of a current CPR card or certification.

IF THE ANSWER TO ANY OF THE QUESTIONS BELOW (#'s 17-24) IS "YES," YOU MUST SUBMIT A FULL AND COMPLETE EXPLANATION AND CERTIFIED COPIES OF ALL APPLICABLE COURT RECORDS AND/OR OTHER LEGAL DOCUMENTS, INCLUDING ALL STATEMENTS OF DISPOSITION, RELIEF FROM DISABILITIES, CERTIFICATION OF CONDUCT OR OTHER DOCUMENTS.

17. Have you been disciplined or charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. Military, U.S. Public Health Service or other U.S. Federal government entity and are awaiting final disposition by that body? ☐ Yes ☐ No

If Yes, complete and submit the ***Disciplinary Action Questionnaire (PDF)***.

18. Have you ever been denied a license, voluntarily surrendered your license, had your license cancelled, suspended or revoked or permission to practice podiatric medicine or any other healing arts denied in any state, country, or U.S. federal jurisdiction? ☐ Yes ☐ No

If Yes, complete and submit the ***Disciplinary Action Questionnaire (PDF)***.

19. Have you ever had staff privileges in a hospital or other health care facility denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? ☐ Yes ☐ No

If YES, please explain on a separate sheet of paper.

20. Has a claim or action for damages ever been filed against you in the course of practice of podiatric medicine or any other healing art which resulted in a malpractice settlement, judgment, or arbitration award of over &70,000.00? ☐ Yes ☐ No

If YES, please explain on a separate sheet of paper.

21. Are you now, or were you in the past, addicted to or treated for addiction to chemical or controlled substances, such as narcotics or alcohol or other substances? ☐ Yes ☐ No

If YES, please explain on a separate sheet of paper.

22. Have you ever been convicted of or pled nolo contendere to a violation of any federal, state, or local law relating to the manufacture, distribution or dispensing of controlled substances, or to drug addiction? ☐ Yes ☐ No

If YES, complete and submit the ***Criminal History Questionnaire (PDF)***.

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any city, state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $500.00 or less) ☐ Yes ☐ No

If YES, complete and submit the ***Criminal History Questionnaire (PDF)***.

Once your completed application is received, instructions on how to schedule an appointment to be fingerprinted will be emailed to you. Be sure your email address is current and legible to receive the fingerprinting information.
See instructions sheet for more information.

24. Do you have any condition which in any way impairs or limits your ability to practice podiatric medicine with reasonable skill and safety, including but not limited to, any of the following? ☐ Yes ☐ No

If YES, please select the appropriate box(es) below:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ A physical disorder
- ☐ Other (explain): _____

25. APPLICANT'S AFFIRMATION

I, _____ hereby certify, that I am at least twenty-one years of age, and; that I am the person named in this application for a license to practice Podiatric Medicine in the State of Texas, and; that all statements herein are made as a basis of consideration for the Texas Department of Licensing and Regulation, to accept and consider as facts which concern my fitness, professional history and physical qualifications for the rights and privileges of a license to practice Podiatric Medicine in the State of Texas, all of which are true and correct. I voluntarily pledge to refrain from dishonest or fraudulent methods in taking the examination and to refrain from unethical, unlawful or unprofessional conduct in my practice. I shall not by any method, or deceptive means make use of misrepresentations, misleading or untruthful statements to the public or my patients, or in my advertising, on my professional cards, stationary, directories or any other medium. I hereby agree that the violation of this pledge, or any of the provisions of the Podiatric Medical Practice Act of Texas (Section 202.253 and Section 202.501), the Penal Code of Texas (penalty of perjury) shall constitute sufficient cause for the denial, suspension, cancellation or revocation of the license granted to me, and I hereby authorize and grant the Texas Department of Licensing and Regulation the withdrawal of all rights and privileges accrued to me thereunder.

I authorize the release of any information or records held by any individual or agency, relative to my training and qualifications as a Doctor of Podiatric Medicine upon request by the Department for use in evaluating my file.

_____ _____

Signature of Applicant Date

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TO BE COMPLETED BY APPLICANT:

1. Name:

Last, First, Middle Name, Suffix (Jr., Sr., III)

2. Mailing Address:

P.O. Box, Number, Street Name/Apartment Number City State Zip Code

3. Date of Birth: (mm/dd/yyyy)

4. State Licensing Agency:

TO BE COMPLETED BY STATE LICENSING AGENCY:

I certify that _____ who graduated from
Name of Applicant

_____ on _____ was granted license number
Name of Podiatric Medical School Date of Graduation

on _____ , on the basis of _____
Date of License Issued National Board Exam, Licensing Agency Exam, Other

NOTE: If the license was issued by written examination, complete the following certification; otherwise write across the following certification the words: ***Issued on Credentials***.

I further certify that this doctor passed the REGULAR EXAMINATION given by this agency on:
_____ , and obtained a general average of _____percent in the following subjects:
Date

Subjects of Examination	Percent	Subjects of Examination	Percent

I certify that this license is valid, current, has never been suspended or revoked, and will expire on _____ ; and that records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license. If licensee has been disciplined, please provide copies/explanation of agency action.

_____ _____ _____
Type of Print Name of Agency Official Title Name of State Licensing Agency

(Affix Seal)

_____
Signature of Agency Official

Mailing Address:

P.O. Box, Number, Street Name/Apartment Number, City, State, Zip Code

Phone Number:

(Area Code) Phone Number

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MEMORANDUM OF UNDERSTANDING FOR CONDITIONAL ISSUANCE OF TEXAS DOCTOR OF PODIATRIC MEDICINE LICENSE

This Box is For Department Use Only

Name	Applicant Number	Candidate ID Number

I, _____ (Applicant's Name), am currently enrolled in the following approved Graduate Podiatric Medical Education (GPME) residency training program:

Program Name: _____

Program Director Name: _____ Phone Number: _____

Program Category: (e.g., PM&S 36) _____

Program Start Date: _____ End Date: _____

1. For purposes of this agreement, "I", "me" or "you" means the applicant or resident. "The Department" or "the agency" means the Texas Department of Licensing and Regulation.
2. I understand the filing of an application for Doctor of Podiatric Medicine (DPM) does not in any way obligate the Department to issue a license until such time the applicant has been approved as meeting all requirements for licensure set forth in the Department's laws and rules.
3. I understand that upon successful passage of the Department's jurisprudence examination, I may be issued a full license to practice podiatry, which license will be subject to this MOU and to the conditions set forth in Department rule.
4. I understand that upon graduation from the enrolled GPME program, I MUST promptly provide the Department with a certificate of successful completion to evidence my fulfillment of Department Rules.
5. I understand that should I fail to provide the Department with the requisite proof of successful GPME graduation/completion or should I fail to have completed the enrolled GPME program, that I will have not met the requirements for DPM licensure set forth in Department Rule and upon such failure(s) I shall voluntarily surrender the DPM license that was issued to me.
6. I understand that should I fail to provide the Department with requisite proof of materials required for licensure:
   - I have not met the requirements for the DPM license as set forth in Department Rule;
   - I shall voluntarily surrender the DPM license that was issued to me; and
   - I understand that the Department will begin disciplinary proceedings to revoke the DPM license.

I have read and understand the foregoing Memorandum of Understanding.

Signature of Applicant	Date