



# PODIATRIC RESIDENCY FORM

## PLEASE PRINT

This section applies only to applicants who graduate from podiatric college after July 1, 1995. Was your program accredited by the Council on Education of the American Podiatric Medical Association?

\_\_\_\_\_ Yes \_\_\_\_\_ No

### Part I. TO BE COMPLETED BY APPLICANT

Applicant's Name \_\_\_\_\_  
Last First Middle Maiden

### Part II. TO BE COMPLETED BY SUPERVISING PODIATRIST

NO PORTION OF THE REMAINDER OF THIS FORM MAY BE FILLED IN BY THE APPLICANT.

Please return the completed form directly to:

South Dakota Board of Podiatry Examiners  
810 North Main #298  
Spearfish, SD 57783

(Please Print or Type)

The application for licensure cannot be processed until this completed form is received by the Board of Examiners.

1. Name, address and phone number of agency where podiatry experience was obtained:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Name, address and phone number of podiatrist responsible for supervising the applicant's podiatry experience:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

State/Province where supervisor is licensed: \_\_\_\_\_

License # \_\_\_\_\_ Date Issued: \_\_\_\_\_

3. Inclusive dates of applicant's podiatry experience: Starting Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_

4. Applicant's title during podiatry experience: \_\_\_\_\_

5. Applicant's position during podiatry experience: \_\_\_\_\_

6. Applicant worked full time: \_\_\_\_\_ or part-time: \_\_\_\_\_

(hours/week)

(hours/week)

(Over)

**Part II. (continued)**

7. Please describe the nature of the applicant's podiatry experience: \_\_\_\_\_

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8. Based on your overall experience with this applicant, do you personally attest to the competence, professional judgement and ethical conduct prerequisite to the independent, unsupervised practice of podiatry?

Yes \_\_\_\_\_ No \_\_\_\_\_

If NO, please explain: \_\_\_\_\_

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9. What is the applicant not qualified to do in the practice of podiatry? \_\_\_\_\_

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10. Would you hire this applicant as a professional podiatrist? Yes \_\_\_\_\_ No \_\_\_\_\_

If NO, please explain: \_\_\_\_\_

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11. Do you have any reservations that would assist the South Dakota Board of Podiatry Examiners in evaluating this applicant's qualifications to engage in the independent practice of podiatry?

Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please explain: \_\_\_\_\_

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I DO/DO NOT recommend this applicant for licensure in podiatry.

\_\_\_\_\_  
Signature of Supervising Podiatrist

\_\_\_\_\_  
Date