**Montana Board of Medical Examiners**
**PO Box 200513**
**(301 South Park Avenue 4th Floor - Delivery)**
**Helena, MT 59620-0513**
**PHONE: 406-444-6880 FAX: 406-841-2305**
**E-MAIL:** dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.
(Please allow 30 days for processing from the date that the Board has a completed application)

## CERTIFICATION REQUIREMENTS:

- Must be licensed in Montana as a podiatrist; and
- Submit proof of certification by the American Board of Podiatric Surgery in foot and ankle surgery or reconstructive rear foot/ankle surgery; *or*
- Submit proof of current licensure or certification to perform ankle surgery in another state whose licensing standard at the time the license or certificate was issued was essentially equivalent, in the judgment of the board, to those of this state; *or*
- Submit proof of completion of a podiatric surgical residency approved in the year of the candidate's residency by the council on podiatric medical education or the American Board of Podiatric Surgery or successor(s), and submit evidence satisfactory to the board of not fewer than 25 ankle surgeries performed by the applicant and proctored by a primary surgeon of record who is an orthopedic surgeon with foot and ankle experience or a doctor of podiatric medicine with ankle surgery certification within the 5 years immediately preceding this application

**FEES:** **$75.00 - Certification Fee (non-refundable) (One time fee)**
*Make payable to Montana Board of Medical Examiners*

**DOCUMENTS:** The following documents must be submitted to the Board office in order to complete your license application. Please make 8 ½" x 11" copies of the following and submit with your application.

- **Current Verification from all State Licensing Boards where licensed or certified in ankle surgery**
- **Proof of one of the following:**

1) **Certificate from the American Board of Podiatric Surgery; or**

2) **Proof of current licensure from another state with Ankle Surgery Certification; or**

3) **Proof of not fewer than 25 ankle surgeries proctored by a Board Certified Orthopedic Surgeon or Doctor of Podiatric Medicine**

**NOTE: ALL DOCUMENTS NOT IN ENGLISH MUST BE ACCOMPANIED BY CERTIFIED TRANSLATIONS.**

**APPLICATION PROCEDURES:**

- A verification of licensure must be sent directly from the state board(s) in which the applicant is currently or has ever been licensed or certified for ankle surgery. Please make copies of the attached verification request form as needed. Some states may charge a fee for verification. Contact each state board prior to sending the request.
- Keep the Board office informed at all times of any address changes, changes in license status, complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

**PROCESSING PROCEDURES:**

- An application file must be complete before consideration of licensure. You will be notified in writing of any items missing from the application file.
- Allow at least 10 days to process the application from the time it is complete.
- If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration.

**ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE:**

**For information with regard to the processing of this application and other concerns please contact the Board of Medical Examiners staff at (406) 444-6880 or email** dlibsdmed@mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR PODIATRY ON OUR WEBSITE: http://www.medicalboard.mt.gov

# MONTANA BOARD OF MEDICAL EXAMINERS

**(301 SOUTH PARK, 4TH FLOOR - Delivery)**
**P. O. Box 200513**
**Helena, Montana 59620-0513**
**( 406) 444-6880 FAX (406) 841-2305**
**E-MAIL dlibsdmed@mt.gov**
**WEBSITE: www.medicalboard.mt.gov**

**Application for Certification by:**

- ◯ American Board of Podiatric Surgery Certification
- ◯ Ankle Surgery Certification in another state
- ◯ Surgical Residency [pursuant to ARM 24.156.1003(c)]

1. FULL NAME: _____
   Last First Middle
2. OTHER NAME(S) KNOWN BY _____
   (Maiden, Nicknames, Etc.)
3. BUSINESS NAME _____
4. BUSINESS ADDRESS _____
   Street or PO Box # City and State Zip
5. HOME ADDRESS _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS ◯ Business ◯ Home E-MAIL ADDRESS _____
6. TELEPHONE (____) _____ (____) _____ (____) _____
   Business Home Fax
7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____
8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ◯ MALE ◯ FEMALE
   City/State
9. LICENSE NAME _____
   (State your name as it should appear on the license if granted.)
10. Have you ever previously applied for an ankle surgery certification in Montana? If yes, give date and results. ◯ Yes ◯ No
11. Have you ever been denied licensure or the opportunity to take this profession's licensing examination in any state or country? If yes, attach a detailed explanation. ◯ Yes ◯ No
12. Have you ever withdrawn an application for medical licensure? If yes, please give the state and reasons for withdrawal. ◯ Yes ◯ No
13. **CURRENT MONTANA PODIATRIST LICENSE NUMBER:** _____
14. **ABPS Foot/Ankle Surgery Certification:** Attach proof of certification by the American Board of Podiatric Surgery in foot/ankle surgery or reconstructive rear foot/ankle surgery.

**-OR-**

**Ankle Surgery Certification in another state.** List all ankle surgery license/certifications you hold or have **ever** held. Verification must be sent directly to Montana from each state/province/territory.

| State | License # | Issue Date | Expiration Date | License Method | Requested State Verification |
|---|---|---|---|---|---|
| | | | | ◯ Exam ◯ Endorse ◯ Other | ◯ Yes ◯ No |
| | | | | ◯ Exam ◯ Endorse ◯ Other | ◯ Yes ◯ No |
| | | | | ◯ Exam ◯ Endorse ◯ Other | ◯ Yes ◯ No |
| | | | | ◯ Exam ◯ Endorse ◯ Other | ◯ Yes ◯ No |
| | | | | ◯ Exam ◯ Endorse ◯ Other | ◯ Yes ◯ No |
| | | | | ◯ Exam ◯ Endorse ◯ Other | ◯ Yes ◯ No |

**-or-**

**PODIATRIC SURGICAL RESIDENCY** List each podiatric surgical residency. Attach evidence of not fewer than 25 ankle surgeries you performed that were proctored by primary surgeon of record who is an orthopedic surgeon with foot and ankle surgery certification or a doctor of podiatric medicine with an ankle surgery certification within the five years immediately preceding this application.

| NAME OF FACILITY | LOCATION OF FACILITY | DATES | NAME & PHONE NUMBER OF PRIMARY SURGEON OF RECORD |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## PERSONAL HISTORY QUESTIONS - IMPORTANT INSTRUCTIONS AND NOTICE

- Please read the following questions carefully. Giving an incomplete or false answer is unprofessional conduct and may result in denial of your application or revocation of your license. See, 37-1-105, MCA.
- You have a continuing duty to update the information you provide in your application and supplemental responses, including while your application is pending and after you are granted a license.
- Upon submittal of your application form, for every "yes" answer provided, you will receive a request for specific information or documents associated with the question. Your application is not complete until staff receive all information requested.

## PERSONAL HISTORY QUESTIONS

15. Have you ever had any license, certificate, registration, or other privilege to serve as a volunteer or practice a profession denied, revoked, suspended, or restricted by a public or private local, state, federal, tribal, religious, or foreign authority? ◯ Yes ◯ No

16. Have you ever surrendered a credential like those listed in question 15, in connection with or to avoid action by a public or private local, state, federal, tribal, religious, or foreign authority? ◯ Yes ◯ No

17. Have you ever resigned to avoid discipline, been suspended, or been terminated from a volunteer or employment position? ◯ Yes ◯ No

18. Have you ever been required to participate in a behavioral modification or assistance program in lieu of suspension or termination from a volunteer or employment position? ◯ Yes ◯ No

19. Have you ever withdrawn an application for any professional license? ◯ Yes ◯ No

20. As of the date of this application, are you aware of any pending complaint, investigation, or disciplinary action related to any professional license you hold? ◯ Yes ◯ No

21. Are you under a current order that remains unsatisfied (e.g., fines unpaid, probation not concluded, conditions unmet?) ◯ Yes ◯ No

**Note on Questions 22 and 23:** Applicants who disclose medical, physiological, mental, or psychological conditions or chemical substance use in Question 22 or 23 may qualify for participation in the Montana Professional Assistance Program. Please visit the board website for more information about this program. "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

22. Do you have any medical, physiological, mental, or psychological condition which in any way currently (within the last 6 months) impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? ◯ Yes ◯ No

23. Do you currently (within the last 6 months) use one or more chemical substances in any way which impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? ◯ Yes ◯ No

The following information is provided for Question 24 below:

A criminal conviction may not automatically bar you from receiving a license. For more information about how a criminal conviction may impact your application, consult the board or program website.

24. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or sentence deferred or suspended as an adult or "juvenile convicted as an adult" in any state, federal, tribal, or foreign jurisdiction? ◯ Yes ◯ No

25. Are you now subject to criminal prosecution or pending criminal charges? ◯ Yes ◯ No

26. Have you ever been disciplined, censured, expelled, denied membership or asked to resign from a professional society or organization? ◯ Yes ◯ No

27. Have you ever had a civil judgment entered against you in a lawsuit for incompetence, negligence, or malpractice in practicing any profession? ◯ Yes ◯ No

28. Have you ever been disqualified from working with children, elderly persons, mentally ill persons, or other vulnerable persons? ◯ Yes ◯ No

29. Have you ever been placed on probation, restricted, reprimanded, suspended, revoked, resigned in lieu of action against you, or had other action taken against you by any hospital, clinic, health care facility, group medical practice, health maintenance organization, or third-party insurance provider, including Medicare and Medicaid? ◯ Yes ◯ No

30. Are you currently on an exclusion list by the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services prohibiting you from working in a facility receiving federal funding? ◯ Yes ◯ No

31. Has your authority to prescribe, dispense, or administer drugs, including controlled substances, ever been denied, restricted, suspended, or revoked? ◯ Yes ◯ No

32. Have you ever voluntarily surrendered or had your U.S. Drug Enforcement Administration registration placed on probation, restricted, suspended, or revoked? ◯ Yes ◯ No

# AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Legal Signature of Applicant

Date

## VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

**PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A PHYSICIAN. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.**

STATE BOARD: _____

I am applying for a license to practice medicine in the State of Montana. The Medical Board requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

_____ Name: _____
(Signature) (Please print)

Address: _____

_____

My License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

License is current? _____ If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? ◯ Yes ◯ No

If YES, explain and attach documentation _____

_____

Has licensee ever been requested to appear before your Board? ◯ Yes ◯ No

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

**BOARD SEAL**

Signed: _____
Title: _____
State Board: _____ Date: _____