



CERTIFICATE OF PODIATRIC MEDICAL EDUCATION

Official Transcripts of **ALL** podiatric medical education must be submitted directly to the Podiatric Medical Board of California to be acceptable. This form must accompany your transcripts. Use one form for each college or university attended. **Transcript(s) must be mailed directly from the school to the Board to be acceptable.**

TO BE COMPLETED BY APPLICANT:

Please type or print.

Name: _____

Date of Birth: _____

TO BE COMPLETED BY PODIATRIC MEDICAL SCHOOL:

PMBC Use
Only

Name of college/university: _____

Address: _____

Date applicant enrolled in school: _____

Date applicant was issued the degree: _____

Title of degree awarded: _____

The undersigned further certifies that the records of this institution show that he/she attended in this institution _____ courses of resident instruction of _____ weeks each, completing at least 4,000 hours (of at least 50 minutes each) in the subjects set forth hereunder (Business and Professions Code Section 2483), and was granted the degree of Doctor of Podiatric Medicine by the above-mentioned podiatric medicine school on the _____ day of _____.

SUBJECTS OF INSTITUTION

| | | | |
|---|--|--|--|
| Alcoholism and Substance Abuse Detection Biomechanics – Foot and Ankle Child Abuse Detection Orthopedic Surgery Physical Medicine/Therapy Psychiatric Problem Detection Spousal/Partner Abuse Detection | Anesthesia Biochemistry Dermatology Geriatric Medicine Human Sexuality Medical Ethics Pediatric Medicine | Anatomy (incl. Embryology, Histology and Neuroanatomy) Bacteriology, Infectious Disease Pathology, Microbiology and Immunology Pharmacology (incl. Materia Medica and Toxicology) Physical and Laboratory Diagnosis Preventative Medicine (incl. Nutrition) Radiology and Radiation Safety | Behavioral Science Neurology Podiatric Medicine Podiatric Surgery Physiology Therapeutics Women's Health |
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UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

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|--|------------------------------|-----------------------------|--------------------------|
| 1. Did student ever take a leave of absence during medical school? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> |
| 2. Was student ever placed on probation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> |
| 3. Was student ever disciplined or placed under investigation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> |
| 4. Were any negative reports ever filed by student's instructor(s)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> |
| 5. Were any limitations or special requirements imposed on student due to questions of academic or disciplinary problems, or for any other reason? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> |

A "yes" response to questions 1 – 5 requires a signed and dated letter of explanation by school official.

SCHOOL OFFICIAL CERTIFICATION

| | | | |
|----------------------|--|--------------------------|--------------------------|
| AFFIX SCHOOL SEAL | <i>I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.</i> | | <input type="checkbox"/> |
| | PRINTED NAME OF SCHOOL OFFICIAL | TITLE OF SCHOOL OFFICIAL | |
| | SIGNATURE OF SCHOOL OFFICIAL | DATE | |
| | Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that must be attached to this form. Such delegation must be on official letterhead and must be dated within the last 12 months. | | |
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