

# Wisconsin Department of Safety and Professional Services

**Mail To: P.O. Box 8935  
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## PODIATRY AFFILIATED CREDENTIALING BOARD

### CERTIFICATE OF POSTGRADUATE TRAINING

**IMPORTANT:** PLEASE FORWARD THIS FORM TO YOUR POSTGRADUATE TRAINING PROGRAMS (This form may be photocopied)

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PODIATRIST'S NAME: \_\_\_\_\_

HOSPITAL NAME: \_\_\_\_\_

HOSPITAL ADDRESS: \_\_\_\_\_

HOSPITAL TELEPHONE: \_\_\_\_\_

1. In what type and level(s) of training did this podiatrist participate at your facility? Check each level in which podiatrist participated, provide starting and ending dates of his/her training in your program and type of training and whether credit was given for the training.

DATES (MO/YR)	SPECIALTY	CREDIT	NO CREDIT	PARTIAL CREDIT
_____ PGY 1 _____				
_____ PGY 2 _____				
_____ PGY 3 _____				

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b><u>YES</u></b>        | <b><u>NO</u></b>         |
| 2. Was the residency accredited by Council of Podiatric Medical Education (CPME)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Did the podiatrist complete the full training program in good standing?<br>If no, please attach explanation on a separate sheet.                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Was the podiatrist asked to or required to repeat any portion of the training at your facility?<br>If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |

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- |   | <u>YES</u>               | <u>NO</u>                |
|---|--------------------------|--------------------------|
| 5. Was the podiatrist placed on probation, suspended or in any way sanctioned/disciplined while at your facility?<br>If yes, please attach explanation on a separate sheet.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Was this podiatrist granted a leave of absence while training at your facility?<br>If yes, please attach explanation on a separate sheet.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Did this individual have a record of unexcused absences during his/her attendance at this training program?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Were any restrictions and/or special requirements placed on this podiatrist's activities that were not placed on all other residents at his/her level of training?<br>If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Were any formal patient or staff complaints filed against this podiatrist?<br>If yes, please attach explanation on a separate sheet.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Were any incident reports filed involving the professional behavior or conduct of this podiatrist?<br>If yes, please attach explanation on a separate sheet.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Was this podiatrist ever subject to non-routine monitoring while at your facility?<br>If yes, please attach explanation on a separate sheet.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Were any malpractice actions filed naming this podiatrist as a defendant that involved his/her period of training at your facility?<br>If yes, please attach explanation on a separate sheet.                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Is there any additional information in this podiatrist's file that would assist the Board in determining this applicant's eligibility for licensure.<br>If yes, please attach explanation on a separate sheet.              | <input type="checkbox"/> | <input type="checkbox"/> |

Print name of Program Director \_\_\_\_\_

Signature of Program Director \_\_\_\_\_

Date form was completed \_\_\_\_\_

**SEAL OF  
HOSPITAL**

(If hospital does not have a seal,  
a letter attesting to this fact, on  
hospital stationery, must  
accompany this certificate)

**Please return directly to:**

Department of Safety and Professional Services  
Podiatry Affiliated Credentialing Board  
1400 East Washington Avenue  
P.O. Box 8935  
Madison, WI 53708-8935