



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
CERTIFICATION OF INTERNSHIP/RESIDENCY PROGRAM

STATE BOARD OF PODIATRIC MEDICINE
 P.O. BOX 423, 3605 MISSOURI BOULEVARD
 JEFFERSON CITY, MISSOURI 65102-0423
 TELEPHONE (573) 751-0873
 TTY: (800) 735-2966
 WEBSITE: <http://pr.mo.gov/podiatrists>
 EMAIL: podiatry@pr.mo.gov

THIS FORM MUST BE COMPLETED BY THE RESIDENCY DIRECTOR

NAME OF RESIDENT/INTERN (FIRST, MIDDLE, LAST)	
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
UNDERGRADUATE EDUCATION	
SCHOOL OF PODIATRIC MEDICINE	DATE OF GRADUATION
NAME OF APPROVED RESIDENCY IN PODIATRIC MEDICINE	
RESIDENCY TRAINING AND TYPE OF PROGRAM (RESIDENCY TRAINING MUST BE AT LEAST TWELVE (12) MONTHS AND APPROVED BY THE CPME OF THE APMA)	
STARTING DATE OF RESIDENCY PROGRAM	COMPLETION DATE OF RESIDENCY PROGRAM
COMMENTARY OF CLINICAL COMPETENCE AND CHARACTER OF RESIDENT	

PLEASE CHECK ONE OF THE FOLLOWING:

I endorse this person without reservation

I endorse this person with reservation

I do not endorse this person

MUST BE SIGNED IN PRESENCE OF NOTARY	SIGNATURE OF RESIDENCY DIRECTOR	
	STATE OF	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR	
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	

USE RUBBER STAMP IN CLEAR AREA BELOW