



New Jersey Office of the Attorney General
 Division of Consumer Affairs
 State Board of Medical Examiners
 P.O. Box 183
 Trenton, New Jersey 08625
 (609) 826-7100

Podiatry Education Verification Form

Applicant's name: _____

Podiatry school: _____

Podiatry school address: _____
Street City State/Country Zip/Postal Code

Telephone number: (Area Code) _____

1. Did this physician attend the podiatry school noted above? Yes No

2. What were the applicant's dates of enrollment? _____ to _____
Month /Year Month /Year

3. Did this podiatrist graduate from this podiatry school? Yes No

If "No," please explain below:

4. What was the date of graduation? _____
Month /Year

5. Did this individual take a leave of absence during his/her attendance at this podiatry school? Yes No

If "Yes," what was the reason for the leave of absence?

6. Was this individual on probation during his/her attendance at this podiatry school? Yes No

7. Was this individual ever disciplined or under investigation during his/her attendance at this school? Yes No

8. Were any negative reports filed by instructors regarding this individual? Yes No

9. Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? Yes No

Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure.

Print Name of Registrar: _____

Signature of Registrar: _____

Date: _____

Please return **with an official transcript** directly to:

BMEApp@dca.njoag.gov

