

# STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

4201 Patterson Ave, Room 310 • Baltimore, MD 21215-2299 • Phone: 410-764-4785 • Fax: 410-358-3083

## APPLICATION FOR A FULL LICENSE

REQUIRED FORMS AND DOCUMENTS: **\*\*PRIMARY SOURCE DOCUMENTATION REQUIRED**

Item	Description	BOARD USE ONLY	
1.	<b>APPLICATION FORM</b> with recent passport quality color photograph attached to upper right hand corner. Application signature must be <b>notarized</b> .		
2.	<b>FEES: NONREFUNDABLE</b> Application Fee of \$50.00 plus \$1050.00 January Licensure ( <i>issued January 1 – June 30</i> ) \$850.00 July Licensure ( <i>issued July 1 – December 31</i> ) Check payable to: <i>Board of Podiatric Medical Examiners</i>		
3.	<b>PODIATRY COLLEGE TRANSCRIPT – Official Copy</b>		
4.	<b>APMLE (Parts I, II, III)</b> Only certified reports from the Federation of Podiatric Medical Boards are acceptable. <i>Order Reports at <a href="http://www.fpmb.org">http://www.fpmb.org</a>.</i>		
5.	<b>NOTARIZED RESIDENCY AFFIDAVIT</b> or Certification of 5 years practice, whichever is applicable.		
6.	<b>CHRC - Criminal History Records Check</b> (instructions below)		
7.	<b>STATE LICENSURE AFFIDAVIT(S)</b> Applicants that hold or have ever held a license in another state including Limited / Temporary licensure.	1. 3.	2. 4.
8.	<b>TWO (2) REFERENCE LETTERS</b> from podiatrists addressed to the Board One (1) of which must be from a podiatrist licensed in the state you are currently licensed and Practicing.	1. 2.	
9.	Beginning April 2022: Completion of an <b>IMPLICIT BIAS TRAINING PROGRAM</b> approved by the <i>Cultural and Linguistic Health Care Professional Competency Program</i> under § 20-1306 of the Health – General Article. (Notification Only; Course Due At Licensee First License Renewal)	<b>Notification Only.</b> Course Due at First License Renewal	
10.	<b>CURRENT CARDIO PULMONARY RESUSCITATION (CPR) CERTIFICATION</b>		
11.	<b>JURISPRUDENCE ONLINE LECTURE AND EXAM AFFIDAVIT</b>		
12.	<b>JURISPRUDENCE EXAM</b>		

**\*\*PRIMARY SOURCE VERIFICATION:** Defined as verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Verification Documents must be sent to the Board directly from the ORIGINAL SOURCE. Verification documents forwarded to the Board from the applicant are not accepted.

### BOARD USE ONLY

National Practitioner DataBank Query	Date:	Signature:
Jurisprudence Exam and Law Books Mailed	Date:	Signature:
Approval of License	Date:	Signature:

**STATE OF MARYLAND  
BOARD OF PODIATRIC MEDICAL EXAMINERS  
APPLICATION FOR A FULL LICENSE**

*Please Type or Print*

Last Name	First Name	Middle Initial	Maiden Name
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Home Address

City	State	Zip code
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Phone Number	Cell Number	Email Address
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Business Address

City	State	Zip code
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Phone Number

Date of Birth	Place of Birth	Gender (M/F)
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Social Security Number \*

Are you of Hispanic or Latin origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)".

☐ Yes      ☐ No

**Select one or more of the following racial categories:**

1. ☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
2. ☐ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
3. ☐ Black or African American (A person having origins in any of the black racial groups of Africa.)
4. ☐ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
5. ☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)
6. ☐ Other

**Enter Name of Podiatry College Attended and Graduation Date Below:**

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\* Maryland and Federal law requires that the Board obtain the Social Security number or federal tax identification number of any person applying for a professional license for the following purposes:

- Administration of the Child Support Enforcement Program (Md. Code Ann., Family Law § 10-119.3)
- Identification by the Department of Assessments and Taxation of new businesses in Maryland (Md. Code Ann., Health Occ. § 1-210)
- Verification by the Maryland Medicaid program of licensure and sanctions for providers participating in Medicaid (42 U.S.C. § 1396a(a)(49); 42 U.S.C. § 1396r-2; 42 U.S.C. § 1320a-7)

**\* Effective October 1, 2018: CDS prescribing permit requirement for all new licensure applicants**

**All new (initial) licensure applicants** will be required to provide attestation at the time of application for a new CDS prescribing permit, to the Office of Provider Engagement and Regulation (OPER) of completion of a Board approved course (online acceptable) in prescribing and/or dispensing scheduled drugs. This is a requirement by the OPER, if licensed by the Maryland Board of Podiatric Medical Examiners,

All questions about issuance of CDS permits for new licensees or renewing licensees, should be referred to the OPER, the entity regulating these requirements and the issuance of the CDS permits.

OPER: Office of Provider Engagement and Regulation

Local: 410-764-2890

Toll Free: (866) 240-7458

Fax Number: 410-358-1793

Web: <https://health.maryland.gov/OCSA/Pages/home.aspx>

Email: [Maryland.OCSA@maryland.gov](mailto:Maryland.OCSA@maryland.gov).

Please respond to which one of the following is applicable:

- A. POST GRADUATE CLINICAL TRAINING. (List all residency program attended; continue on separate page if required)  
Identify each Residency Program

I)

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Name of Facility

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Address

---

Dates of Post Graduate Training

II)

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Name of Facility

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Address

---

Dates of Post Graduate Training

- B. PRACTICE REQUIREMENT. Please complete all clinical practice locations and dates immediately following completion of your residency to date.

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Note 1: All applicants must have either completed two (2) years of post graduate training in a residency program or have a least (5) years in active clinical practice preceding application to be eligible for licensure in Maryland.

List state(s) in which you are licensed to practice podiatry or have ever been licensed including any licenses issued during residency. Please note that each Licensing Board for the state listed must complete a Licensure Affidavit form **to be sent directly to the Board of Podiatry in Maryland.**

State: \_\_\_\_\_  
License Number \_\_\_\_\_  
Date of original issuance: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

State: \_\_\_\_\_  
License Number \_\_\_\_\_  
Date of original issuance: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

State: \_\_\_\_\_  
License Number \_\_\_\_\_  
Date of original issuance: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

State: \_\_\_\_\_  
License Number \_\_\_\_\_  
Date of original issuance: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

Continue on separate page if required

1. Is your application for licensure before another State Board at this time? ☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

2. Has your license to practice in any State ever been subject of an investigation and/or disciplinary action? ☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

3. Has your application for a podiatric license ever been withdrawn or denied for any reason? ☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

4. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system? ☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

5. Has any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal entity denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or non-judicial punishment? If you are under a Board Order in a state other than Maryland or have ever been, you must enclose a certified copy of the Order with this application.

☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

\_\_\_\_\_

6. Have you ever been convicted of a crime? ☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

\_\_\_\_\_

7. Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations?

☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

\_\_\_\_\_

8. Have you ever been addicted to, or treated for addiction to drugs or alcohol? ☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

\_\_\_\_\_

9. Have you pled guilty, nolo contendere, had a conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

\_\_\_\_\_

10. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

11. Have you been named as a defendant at any stage of a medical malpractice and/or medical negligence action?" If yes, please provide a procedural summary of the matter as well as a current copy of your National Practitioner Data Bank report.

☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

12. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal entity?

☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

13. Has your employment been affected or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal entity for any disciplinary reasons or while under investigation for disciplinary reasons?

☐ YES ☐ NO

If yes, give details: \_\_\_\_\_

**\*\*[Reference Letters Requirements for New Applicants Only and not for Reinstatements]\*\***

Please list two (2) podiatrists who will be providing a reference on your behalf as to character, reputation and proof of practice. Request them to send their letters directly to the Board.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**AFFIDAVIT**

I, \_\_\_\_\_ being duly sworn do hereby swear that I am the person in this application for licensure before the Maryland Board of Podiatric Medical Examiners, and that the statements herein contained are true in every respect. If granted licensure, I will comply with all requirements of the laws governing the practices of podiatry in the State of Maryland, and pledge that I shall abstain from all deceptive and fraudulent methods of practice, immoral, unethical unprofessional conduct and will conduct my practice in accordance with the Code of Ethics adopted by the profession.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
NOTARY PUBLIC

My commission expires \_\_\_\_\_

SEAL  
AND  
STAMP

Forward completed application to:

Board of Podiatric Medical Examiners  
4201 Patterson Avenue, Room 310  
Baltimore, Maryland 21215-2299





## STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

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### STATE LICENSURE AFFIDAVIT

THIS PORTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO LICENSING BOARD(S) IN THE STATE(S) WHERE LICENSED.

_____ Last	_____ First	_____ Middle
_____ Date of Birth	_____ Social Security Number	
_____ State Board	_____ Podiatry College & Date of Graduation	

THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD  
AND FORWARDED DIRECTLY TO THE BOARD OF PODIATRY IN MARYLAND.

License Number: \_\_\_\_\_ Date of Original Issue: \_\_\_\_\_

Is License in Good Standing? YES ☐ NO ☐ Expiration Date of License: \_\_\_\_\_

License Type: ☐ Full/Unrestricted ☐ Temporary/Limited ☐ Other, please specify: \_\_\_\_\_

Licensed by: ☐ State Examination ☐ without Examination ☐ Other, Please specify: \_\_\_\_\_

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES ☐ NO ☐ If "yes", please attach documentation

Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? YES ☐ NO ☐ If "yes", please attach documentation

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state? YES ☐ NO ☐ If "yes", please attach documentation

\_\_\_\_\_  
Form Completed by: Title

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
State Board

**NOTARY SEAL &  
STAMP (Not valid  
without seal)**



# STATEBOARDOFPODIATRIC MEDICAL EXAMINERS

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## RESIDENCY AFFIDAVIT

THIS PORTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO THE RESIDENCY PROGRAM(S) ATTENDED

\_\_\_\_\_  
Last Name First Middle

\_\_\_\_\_  
Date of Birth Social Security Number

\_\_\_\_\_  
Facility Name/Dates of Attendance

\_\_\_\_\_  
Facility Address

.....

### THIS PORTION TO BE COMPLETED BY THE RESIDENCY PROGRAM DIRECTOR

**This is to certify that the above named applicant:**

☐ is currently attending and has now successfully completed \_\_\_\_\_ years of postgraduate clinical training in the program listed above with the expected graduation date of \_\_\_\_\_.

☐ has successfully completed three years of postgraduate clinical training in the program listed above on \_\_\_\_\_.

☐ has only completed \_\_\_\_\_ years before leaving the program on \_\_\_\_\_ due to reason:

\_\_\_\_\_  
Explanation Required

\_\_\_\_\_  
Name & Title of Program Director Office Telephone

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

\_\_\_\_\_  
Printed full name of Notary Commission Expiration Date

\_\_\_\_\_  
Signature of Notary

**NOTARY SEAL & STAMP**  
**(Not valid without seal)**



## STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

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### PRACTICE AFFIDAVIT

THIS PORTION TO BE COMPLETED BY APPLICANT AND RETURNED TO THE BOARD WITH THE APPLICATION

\_\_\_\_\_  
Last First Middle

\_\_\_\_\_  
Date of Birth Social Security Number

\_\_\_\_\_  
Practice Name 1

\_\_\_\_\_  
Practice Address 1

\_\_\_\_\_  
Dates of Practice 1

\_\_\_\_\_  
Practice Name 2

\_\_\_\_\_  
Practice Address 2

\_\_\_\_\_  
Dates of Practice 2

Use additional copies of this form if additional practice location information is needed.

**This is to certify that the above named applicant:**

☐ has successfully completed five years of active practice immediately preceding the application for licensure.

\_\_\_\_\_  
Signature of Applicant Date

( )  
Telephone [ ] mobile [ ] landline

NOTARY SEAL & STAMP  
(Not valid without seal)

STATE BOARD OF PODIATRIC MEDICAL EXAMINERS  
APPLICATION FOR FULL PODIATRIC MEDICAL EXAMINER LICENSURE

**ATTENTION**

**VETERANS EMPLOYMENT ACT OF 2013**

Senate Bill 273, Veterans Employment Act of 2013 became effective July 1, 2013 requiring specified licensing units and Boards to give credit to former service members for relevant military training, education, and experience in connection with the issuance of occupational and professional licenses, certificates, and registrations. The Bill establishes processes for issuing licenses to military spouses who hold an occupational or professional license in another state.

IF YOU ARE A VETERAN, SERVICE MEMBER OR MILITARY SPOUSE, PLEASE REVIEW  
AND  
COMPLETE BEFORE PROCEEDING

*“Service Member” means an individual who is an active duty member of:*

*The Armed Forces of the United States;  
A reserve component of the Armed Forces of the United States; or  
The National Guard of Any State*

*“Veteran” means a former service member who was discharged from active duty under circumstances other than dishonorable within 1 year before the date on which an application for licensure, registration, or certificate is submitted.*

*“Military Spouse” means the spouse of a service member or veteran and includes a surviving spouse of a veteran service member who died within one year before a license or certificate application is submitted.*

**COMPLETE THIS INFORMATION ONLY IF YOU MEET ONE OF THE FOLLOWING  
CRITERIA**

Please place an X in the appropriate box.

☐

*Service Member - Currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any State. (Provide DD1173 Military Id card)*

☐

*Veteran – Discharged from active military duty under circumstances other than dishonorable within the one year of submitting the application. (Provide DD214)*

***Military Spouse:***

☐

*Spouse is a Veteran. (Provide DD214)*

☐

*Spouse was a service member who died within one year before the date of submitting the application. (Provide DD2765- Uniformed Services Identification card)*

☐

*Spouse is a Service Member currently serving in the U.S. Armed Forces, a reserve component of the Armed Forces or National Guards of any State. (Marriage certificate and uniformed Services Identification card DD2765).*

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***Signature of Applicant***

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***Date***

## **Article - Health Occupations**

§1-225.

(a) An applicant for the renewal of a license or certificate issued by a health occupations board under this article shall attest in the application that the applicant has completed an implicit bias training program approved by the Cultural and Linguistic Health Care Professional Competency Program under § 20-1306 of the Health – General Article.

(b) The requirements of subsection (a) of this section shall apply only to an applicant's first license or certificate renewal after April 1, 2022.



STATE OF MARYLAND

DHMH

Maryland Department of Health

State Board of Podiatric Medical Examiners

## **Criminal History Records Check**

A full Criminal History Records Check is a requirement for a license from the Maryland Board of Podiatric Medical Examiners. A full background check includes both State and FBI checks. The Department of Public Safety and Correctional Services, Criminal Justice Information System (CJIS) oversees Criminal History Record Checks. History record checks are conducted by being fingerprinted.

**CJIS AUTHORIZATION #: 1600003705**

**FBI ORI #: MD 920531Z**

**REASON FINGERPRINTED: Podiatric License**

## **TYPE OF CHECK: Governmental Licensing/Certification**

The cost is a \$31.25 CJIS background check fee, plus a fee for fingerprinting services decided by the facility or private provider at the location convenient to the applicant. For instance, the processing fee at the CJIS location is \$20.00; therefore, an applicant would pay \$51.25 in total. Those fees, if you are an in-State applicant, are paid directly to the provider and the time of fingerprinting. If you are an out of State applicant please see below. For additional information contact CJIS at 410-764-4501 or visit <https://www.dpscs.state.md.us/publicservs/fingerprint.shtml>

All applicants for licensure in Maryland will be required to submit fingerprints. This can be accomplished in two ways depending on if you are a Maryland resident or not. In order to comply with the regulations and not delay the issuance of a license or registration, follow the following directions.

4201 Patterson Avenue, – Baltimore, Maryland 21215-2299

website: [www.health.maryland.gov/mbpme](http://www.health.maryland.gov/mbpme)

Toll Free 1-877-4MD-DHMH • TTY for Disabled – Maryland Relay Service 1-800-735-2258



**STATE OF MARYLAND**  
**DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES**  
**CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY**

**LIVESCAN PRE-REGISTRATION APPLICATION**

**APPLICANT INFORMATION** *(PLEASE TYPE OR PRINT CLEARLY)*

Name:

Date of birth:

SSN:

Gender: ☐ Male ☐ Female *(Please check)*

Height:     ft.     inches

Weight:     lbs.

Eye Color:

Hair Color:

Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American ☐ Other *(Please check)*

Place of Birth:

Citizenship:

Current address:

City:

State:

ZIP Code:     -

Daytime Phone:

Evening Phone:

Driver's License #:

**AGENCY INFORMATION**

Agency Authorization #: 1600003705

ORI # (if required): MD920531Z

Reason fingerprinted? Licensing

Position Applied for: Board of Podiatric Medical Examiners

Request Type: *(Choose one ONLY)*

- ☐ Adult Dependent Care
- ☐ Attorney/Client
- ☐ Child care
- ☐ Criminal Justice
- ☐ Gold Seal/ Adoption
- ☐ Gold Seal/Letter/VISA
- ☐ Government Employment

- ☒ Government Licensing or Certification
- ☐ Immigration/VISA
- ☐ Individual Challenge
- ☐ Individual Review
- ☐ MSP Licensing
- ☐ Private Party Petition
- ☐ Public Housing

**Mail Response to:**

(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name:

Address:

City, State, Zip code:



## **Maryland Resident**

Effective October 1, 2020, all in-state applicant fingerprint cards submitted to the Maryland Criminal Justice Information System - Central Repository must be done so electronically via an approved live scan fingerprinting unit. The only time in-state ink-and-rolled applicant fingerprint card will be accepted will be when there is a bona-fide medical reason a live scan transmission cannot be obtained.

There are over one hundred (100) locations available throughout the State that conduct live scan electronic fingerprinting. A list of locations is available online at:

<http://dpscs.maryland.gov/publicservs/fingerprint.shtml>.

Maryland residents may have fingerprints taken prior to mailing an application to the Board. Maryland residents must have the CJIS Authorization number and FBI ORI number with you or use the pre-filled form specific to this Board (link at end of this document and also available on this Board's Forms page). Please note that these numbers are specific to the Maryland Board of Podiatry.

After your fingerprints are taken you will be given a receipt for payment. Forward a copy of the receipt to the Board.

Once the results of the background check are received by the Board the application process will be completed in accordance to Board regulations and policies.

## **Out-of-State Resident**

If you live or work close to the State of Maryland you have the option of using a Maryland location for your fingerprinting. If you use a Maryland location you must follow the instructions for Maryland residents.

Once the Board receives your application, upon request you can be sent a fingerprint card containing Board-specific CJIS Authorization number and the FBI ORI number. You can then have your fingerprints taken at a location convenient for you.

Once the fingerprint process is complete you must mail the fingerprint cards to the following address with a check for \$31.25 payable to the "CJIS Central Repository."

**CJIS Central Repository  
PO Box 32708  
Pikesville, MD 21282-2708**

For additional information contact CJIS via telephone at 410-764-4501; or via their website at <http://www.dpscs.maryland.gov/publicservs/fingerprint.shtml>

After your fingerprints are taken you will be given a receipt for payment. Forward a copy of the receipt to the Board.

Once the results of the background check are received the application process will be completed in accordance with Board regulations and policies.

Effective October 1, 2016

**An initial license will not be issued unless proof of the CHRC is on file with the Board.**

This is a requirement prior to the issuance of a license.

Individuals holding a limited license will be required to submit evidence of the CHRC to the Board prior to the limited license being converted to a full license provided all other requirements for licensure are met. **A full license will not be issued unless proof of the CHRC is on file with the Board.**

Please **do not** call the Board's offices for an update on a background check. The background check is completed by a separate State agency. The Board has no control over the amount of time it takes to complete the background check. If you have not received the results of the criminal history background check after thirty days, please contact CJIS directly at 410- 764-4501.

### **Electronic Fingerprinting**

Electronic fingerprinting locations are provided on the Department of Public Safety & Correctional Services website. Click below for immediate access to fingerprinting locations in Maryland.

<https://www.dpscs.state.md.us/publicservs/fingerprint.shtml>

All applicants must complete the **LiveScan Pre-Registration Application** and take or mail, as relevant, to the fingerprinting location in Maryland.

Please refer to § 16-302.1 Criminal History Record Checks of the Maryland Board of Podiatric Medical Examiners for a full description of the requirements.