STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

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

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)