STATE OF VERMONT
BOARD OF MEDICAL PRACTICE
280 State Drive, Waterbury, VT 05671-8320
AHS.VDHMedicalBoard@vermont.gov

APPLICATION FOR LIMITED TEMPORARY PODIATRIST LICENSE

STATEMENT OF SUPERVISING PODIATRIST / PROGRAM DIRECTOR

This section must be completed by the Supervising podiatrist/Program Director who will be supervising your work in Vermont. This licensed podiatrist will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow, or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. This limited temporary license shall be revoked upon the death or legal incompetence of the licensed physician or upon ten days written notice of the licensed physician.

I certify that (name of applicant) _____ is under my direct supervision and control **in an approved residency program** at:

Hospital or Institution: _____

Department: _____

Address: _____

City, State, Zip Code: _____

For the period _____ to _____

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

_____ _____
Signature of Program Director/Supervising Podiatrist | Program Director/Supervising Podiatrist's Vermont License Number

_____ _____
Printed Name of Program Director/Supervising Podiatrist | Date

_____
Address

_____
City, State, Zip Code

PLEASE EMAIL OR MAIL COMPLETED FORM TO THE BOARD'S ADDRESS LISTED ABOVE. THANK YOU.

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STATEMENT OF THE PROGRAM DIRECTOR

(THIS FORM IS TO BE USED FOR RESIDENTS PARTICIPATING IN AN AWAY ROTATION ONLY)

This section must be completed by the Director of the residency program in which the applicant is currently engaged.

I certify that (name of applicant) _____ is engaged as an intern, resident, fellow, or medical officer at:

Hospital or Institution: _____

Department: _____

Address: _____

City, State, Zip Code: _____

For the period _____ to _____

I further state that (name of applicant) _____ is a resident/fellow in good standing and is scheduled to participate in an **away rotation** at:

Hospital or Institution: _____

Department: _____

Address: _____

City, State, Zip Code:
_____

For the period _____ to _____. This is an approved rotation within the framework of the residency program.

_____ _____
Signature of Program Director Date

_____
Printed Name of Program Director

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