**Complete forms must be sent directly from the supervisor to:**

**Board *of* Podiatric Medicine**
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258
Fax: (850) 413-6982

Email: MQA.Podiatricmedicine@flhealth.gov

# Board *of* Podiatric Medicine
# Certified Podiatric X-Ray Assistant Update Supervisor Form

**Part I: To be completed by licensee**

Name: _____

Address: _____
Mailing Address City State ZIP

Home/Cell Telephone: _____ Work/Cell Telephone: _____

License Number: _____

**Part II: To be completed by each Podiatric Physician who will supervise assistant(s)**
(Make copies if necessary.)

Individual Application Group Application

**Part III: Supervising Podiatric Physician Data**
(If group practice, use name of the president or managing partner.)

Name of Group: _____

Name: _____

Address: _____
Practice Location City State ZIP

Telephone: _____ License Number: _____

Applicant Signature _____ Date _____
MM/DD/YYYY

Supervising
Physician Signature _____ Date _____
MM/DD/YYYY

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