# PODIATRIC RESIDENT HOSPITAL PROGRAM REPORT

**PROGRAM DIRECTOR** —– Each new resident must complete the Podiatric Resident Registration form DH-MQA 1139, a copy of which must be attached to this report.

**DO NOT REPORT "LICENSED RESIDENTS" ON THIS FORM**

**ANNUAL PERIOD:** ____________________**THRU**__________________________

**NAME OF REPORTING HOSPITAL:** ____________________________________________

**PROGRAM DIRECTOR:** ______________________ **Telephone Number (   )** _____________

**Program Address:** ________________________________

________________________________

**Mailing:** __________________________________

__________________________________

**EMAIL ADDRESS:** ________________________________________________

**Section A – Podiatric Physicians on staff or who otherwise serve in a supervisory position:**

NAME LICENSE #

______________________________________________________________

______________________________________________________________

______________________________________________________________

(Attach supplemental list as needed)

**Section B – Podiatric Residents beginning residency during this reporting period. (Please note that if a podiatric resident was listed in this area last reporting period, they are not listed here again but listed in Section C):**

NAME RESIDENCY BEGINS RESIDENCY ENDS

______________________________________________________________

______________________________________________________________

______________________________________________________________

(Attach supplemental list as needed)



Division of Medical Quality Assurance - Board of Podiatric Medicine
4052 Bald Cypress Way, Bin #C07 - Tallahassee, FL 32399-3257
www.doh.state.fl.us/mqa/podiatry
(850) 245-4355

**Section C – Podiatric Residents continuing in residency:**

| NAME | RESIDENCY BEGAN | RESIDENCY ENDS |
|---|---|---|
| | | |
| | | |
| | | |

(Attach supplemental list as needed)

**Section D – Podiatric Residents who completed residency:**

| NAME | RESIDENCY BEGAN | RESIDENCY ENDED |
|---|---|---|
| | | |
| | | |
| | | |

(Attach supplemental list as needed)

**Section E – Podiatric Residents who have withdrawn:**

| NAME | RESIDENCY BEGAN | RESIDENCY ENDED |
|---|---|---|
| | | |
| | | |
| | | |

(Attach supplemental list as needed, indicate status with regard to rights and qualifications for readmission)

**ATTACH COPY OF HOSPITAL'S MOST RECENT RESIDENCY PROGRAM EVALUATION BY THE COUNCIL ON PODIATRIC MEDICAL EDUCATION**

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Signature of Program Director Date


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