Professional Credential Services, Inc.

P.O. Box 198689 - Nashville, TN 37219-8689 (877-887-9727)

Have the affidavit that applies to you completed.

RESIDENCY PROGRAM AFFIDAVIT

I, _____, certify that _____
(Doctor's Name) (Applicant's Name)

*has completed / will complete [circle one] an approved residency program of Podiatric Medicine and

Surgery at _____ which began on _____,
(Name of Institution) (Month and day)

20_____and ended/will end on _____, _____.
(Year) (Month and day) (Year)

_____ _____
(Date) (Signature of Supervising Doctor)

PRECEPTORSHIP PROGRAM AFFIDAVIT

I, _____, certify that _____
(Doctor's Name) (Applicant's Name)

*has completed / will complete [circle one] an approved residency program of Podiatric Medicine and

Surgery at _____ which began on _____,
(Name of Institution) (Month and day)

20_____and ended/will end on _____, 20_____. I have included a
(Year) (Month and day) (Year)

log of my duties and responsibilities during my preceptorship.

_____ _____
(Date) (Signature of Supervising Doctor)

* **If you circle "will complete," please confirm expected date of completion: _____**
Documentation signed by a Supervising Doctor must be sent to PCS within 10 days of completion of residency or preceptorship.
Month/Day/Year

_____
Signature of Applicant