

**New York State Podiatric Medical Association &
New York College of Podiatric Medicine**

2020 Virtual Radiology Course
Application for Unlicensed Persons

****This course is for podiatric assistants working under NYS podiatrists. Assistants practicing in offices in other states will NOT be able to transfer this certification to their home state as it is a NYS-specific privilege to license unlicensed individuals in radiography.**

The new virtual format requires supervising DPM to proctor the exam and provide access to Xray machine.

Course Date & Time: Wednesday, March 9, 2022, 9am-5pm

Course Location: Virtual- Access link will be provided after registration.

Registration Deadline: Friday March 4, 2022

Registration contact: Sonia Lunn

Email: slunn@nyspma.org,

Phone: 212-996-4400

Fax: 646-672-9344

Office Address (if mailing payment, please email to let us know):

NYSPMA, Attn: Sonia Lunn
555 8th Avenue, Suite 1902
New York, NY 10018

Materials Needed:

1. Payment & Application (included)
2. Student & DPM Attestation Form (Included)
3. Diploma (High School, or equivalent/ higher degrees accepted)
(GED, High School Equivalency, College & Masters are O.K.)
4. Letter of moral character from applicant's employer on company stationery

Please Send All Materials Together

**Attestation Form: Outlining the Responsibilities of Supervising DPMs
For the Virtual Radiology Course for Unlicensed Podiatric Assistants**
Provided by NYSPMA & NYCPM

NYSPMA & NYCPM will be offering the Radiology Certification for unlicensed podiatric assistants as a hybrid virtual & hands-on course due to the limitations on large gatherings during the COVID-19 pandemic. In order to uphold the educational quality of this course during these unprecedented times and demonstrate compliance with the certification requirements, a supervising DPM must be available to proctor the mandatory written and practical components of this course in an office setting (with access to Radiography Equipment), verifying and documenting compliance for subsequent certification.

The lecture portion of this exam will be given remotely by the New York College of Podiatric Medicine through video conference. The proctored written exam will be provided and evaluated by NYCPM. The practical component will be video recorded under the supervision of a DPM. The exam will consist of a specific list of learning objectives and skills that the student must successfully demonstrate on an x-ray machine provided by the supervising DPM in the office setting. This video recording will be sent to the radiology department at NYCPM for final review before certifications are issued.

This certification has always been available to unlicensed podiatric assistants under the supervision of a licensed DPM. As such, it is the ultimate responsibility of the DPM to ensure that assistants are capable of safely completing all necessary skills before they are allowed to do so on patients.

Day-of Course Requirements:

- Reliable Wireless Connection for the duration of the 8-hour course.
- Xray Machine
- Supervising DPM time commitment will be a maximum of 1 hour to proctor the written exam & practical component
- Smart Phone, or another device with video recording capabilities & the ability to email this recording.

All supervising DPMs are required to uphold the integrity of the written and practical exam components of this certification course. We expect this to be an educational experience at least to the standard of, if not higher, than the previously offered on-site course. We hope this new virtual format will be convenient for our members and non-member participants as it will eliminate the necessity for travel time and expenses related to the historically on-site format of this course.

Supervising DPM: (print) _____ (&sign) _____

Student Name: (print) _____ Date: ____/____/____



NYSPMA Podiatric Radiography Course for Unlicensed Individuals in NYS

REQUIREMENTS:

1. Applicants must be at least 18 years old
2. Applicants must have a high school diploma or equivalent or Post-Secondary Diploma– **Attach copy of diploma or GED**
3. Applicants must be of good moral character – **Supply letter from doctor attesting to character**
4. Applications must be submitted in completion. We do not accept applications that do not have all four necessary components (Registration form, application, HS diploma or equivalent, letter of moral character) or are submitted in piecemeal.

PERSONAL INFORMATION:

Name: _____

c/o Doctor/Employer: _____

Office Address _____

City _____

State _____

Zip _____

Telephone: _____

Fax: _____

Email (REQUIRED): _____

PAYMENT INFORMATION:

☐ \$295 Per Registrant (NYSPMA Member's Staff)

☐ \$595 Per Registrant (Non Member's Staff)

Complete registrations will not be processed without payment.

- To pay by credit card: Scan and Email form to slunn@nyspma.org (we highly recommend this method) or fax to 646-672-9344 to the attention of Sonia Lunn
- To pay by phone, contact Rashmi Doshi at 212-996-4400

☐ Check Enclosed Amount \$ _____

☐ MasterCard ☐ Visa Amount \$ _____

Card Holder Name _____

Card # _____

Exp. Date _____

Signature _____

Security Code _____

CANCELLATION POLICY:

Registrations cancelled by **Friday March 4, 2022** will be refunded in full, minus a \$25.00 processing fee. All cancellation requests must be emailed to slunn@nyspma.org. No refunds will be issued after **Friday March 4th, 2022**.

DEADLINE AND CONDITIONS TO APPLY:

All COMPLETE applications (Registration form, application, high school diploma, and letter of moral character, and DPM attestation form) must be received by Friday March 4th, 2022.

QUESTIONS?

Email Sonia Lunn at slunn@nyspma.org or call the NYSPMA office and ask to speak to Sonia Lunn at 212-996-4400

Please email this application att: Sonia Lunn at NYSPMA
New York State Podiatric Medical Association
555 8th Avenue
New York, NY 10018
Office Phone: (212) 996-4400

**APPLICATION FOR A PODIATRIC RADIOGRAPHY COURSE
FOR UNLICENSED INDIVIDUALS**

APPLICANTS MUST COMPLETE ALL PAGES OF THIS APPLICATION **IN INK, WRITTEN LEGIBLY**
IF YOU DO NOT HAVE CLEAR HANDWRITING PLEASE TYPE THE INFORMATION AND SIGN IN INK

BIRTH DATE: ____/____/____
month day year

PRINT NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR CERTIFICATE:

Last: _____

First: _____

Middle: _____

MAILING ADDRESS:

Apt./Bldg _____

Address: _____

City: _____ State: _____ Zip Code: _____

TELEPHONE/FAX and EMAIL:

Home: (____) ____ - ____ Work: (____) ____ - ____

Fax: (____) ____ - ____ Email: _____

(IMPORTANT: You must notify the State Education Department promptly of any address or name changes.)

Do you now hold, or have you ever held, a license or certificate to practice in any profession in any jurisdiction? ☐ YES ☐ NO

(If so, list below and attach other pages as needed.)

Profession	License Number	Jurisdiction
Profession	License Number	Jurisdiction
Profession	License Number	Jurisdiction

Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ☐ YES ☐ NO

Are criminal charges pending against you in any court? ☐ YES ☐ NO

Are charges pending against you in any jurisdiction for any sort of professional misconduct? ☐ YES ☐ NO

NOTE: If you answer "Yes" to any of the above three questions, submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

EDUCATION

In the spaces below, give an accurate record of your postsecondary educational preparation. List all colleges attended and degrees received. (Attach additional sheets if necessary.)

SCHOOLS ATTENDED AND LOCATIONS	NUMBER OF YEARS ATTENDED	ATTENDANCE		DIPLOMA OR DEGREE OBTAINED
		Entrance Date	Leaving Date	

REASONABLE TESTING ACCOMMODATIONS FOR INDIVIDUALS WITH DISABILITIES

I have been diagnosed as having a disability and require reasonable testing accommodations. Please check one:

- ☐ Please send the **Request for Reasonable Testing Accommodations** form. I understand that I will not be able to test until I submit the appropriate documentation and am approved to test with accommodations.
- ☐ I have already received a Request for Reasonable Testing Accommodations form from the Office of the Professions.
- ☐ I have already sent in my Request for Reasonable Accommodations Form and required supporting documentation to the Office of the Professions.

CITIZENSHIP/IMMIGRATION STATUS:

Federal law limits the issuance of this certificate to United States citizens or qualified aliens. To comply with this Federal Law, complete this section of this form and check the appropriate box below which indicates your citizenship/immigration status.

I am: (Check one box)

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> A United States citizen or National. | <input type="checkbox"/> An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least 1 year. |
| <input type="checkbox"/> An alien lawfully admitted for permanent residence in the United States. | |
| <input type="checkbox"/> An alien granted asylum under Section 208 of the Immigration and Nationality Act. | <input type="checkbox"/> An alien whose deportation is being withheld under Section 243 (h) of the Immigration and Nationality Act. |
| <input type="checkbox"/> A refugee granted asylum under Section 207 of the Immigration and Nationality Act. | <input type="checkbox"/> An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980. |
| <input type="checkbox"/> Non-Immigrant (Temporarily in U.S.)
Please list Visa type or immigration status or attach a copy of your passport if you are not required to have a Visa to enter the United States: _____ | |

If you are not a United States citizen please enter your registration, Visa, or receipt number issued by the Immigration and Naturalization Service: _____

QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE IMMIGRATION AND NATURALIZATION SERVICE (INS) AT: 1-800-375-5283.

GENDER AND ETHNICITY: (This item is optional)

Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

GENDER: ☐ Male ☐ Female

ETHNICITY: ☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Asian ☐ Hispanic ☐ Native American

AFFIDAVIT

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of certificate.

Signature of applicant: _____ Date: _____