CONGRUENT THOUGHTS
By Mitchell D. Shikoff, DPM, FACFAS

Hello again to all of you who comprise the future of our Board and your chosen profession. This issue of your connection to the ABPM is going to be a bit of a change from our prior format. I hope that you find it insightful, interesting, and thought provoking.

Our last issue was packed with useful information including: No case docs needed for PMSR, PMS-36, PMS–24 plus PPMR resident graduates in order to become ABPM certified; Biomechanical Considerations in Surgical Planning; Essentials and Tips for Accurate Orthopedic Foot and Ankle Diagnosis; and Why Case Logging is Important. Find the last copy in the Residents section of our ABPMed.org website.

In this issue we are going to address what the future holds for you. The uncertainties may actually be opportunities. It all depends on one’s approach.

We all know Dr. Warren Joseph, the podiatric infectious disease specialist extraordinaire, and I might add, an ABPM diplomate. If you don’t, you will now. Dr. Joseph gives us a perspective that he has never written about previously. There’s not one organism in the article that you’ve never heard about!

A LITTLE ON DR. JOSEPH...

Dr. Joseph graduated from the SCPM and is currently on staff at Roxborough Memorial Hospital outside of Philadelphia as a consultant in lower extremity infectious diseases. Dr. Joseph is married to his wife, Judy, a Physician Assistant, for 28 years and he has two grown sons. His hobbies include travel, photography, astronomy and amateur (ham) radio. He enjoys hiking the Red Rocks of Sedona, AZ. The only sports team that he supports is the Philadelphia Phillies, but he admits that the support is contingent on them putting together a decent team this year.

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Congruent Thoughts continued ~

Have you ever thought about treating celebrities, prominent athletes, or well-known politicians? This edition introduces you to someone who has done just that. Dr. Joseph D'Amico practices in New York City and recently had the opportunity to treat a well-known comedic actor, Jerry Seinfeld. We have the details, and in case you’re wondering, we have Jerry’s permission. Jerry was so happy with Dr. D’amico’s treatment, he was willing to divulge his medical details in order that it may help other practitioners treat other patients with similar problems. Forget medication, injections, and surgery. This case was solved with Biomechanics!

A LITTLE ON DR. D’AMICO...
Dr. D’Amico has long been associated with biomechanics. He completed a fellowship in biomechanics at the California College and is a professor in orthopedics at the New York College. We are proud to say that he is a diplomate of the ABPM. Dr. D’Amico is married with two sons and resides in Westchester, NY.

NEW APPROVED BIOMECHANICAL EXAM FORM
The ABPM has recently adopted a new biomechanical exam form that can be utilized to fulfill your residency requirements. It is concise, but covers all the salient aspects. We encourage you to use this form. It is approved by the CPME. It is available on the CPME website, as well as our ABPM website.

THE RESIDENCY SHORTAGE
As you all know, we currently have an issue with a shortage of residency programs for graduating podiatric medical school students. The ABPM wants you to know that we are continuing to work with hospitals and podiatrists to make more slots available. You should also know that we are continuing to fund the residency facilitator position established by the APMA two years ago. We have helped to fund this position since its inception.

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PAYING IT FORWARD.

Obstacles can be overcome if we work together to help one another.
The American Board of Podiatric Medicine
RESIDENT NEWSLETTER

OVERCOMING OBSTACLES...

During these uncertain times for graduating podiatric medical school students and residents, it is sometimes gratifying to know that the bleakest of situations can be turned into something grand. Students wonder if they’ll match with a residency and residents wonder will they get a job. I personally know of a podiatrist from the Philadelphia area who graduated from the Illinois Podiatric Medical School in the early eighties. At that time, the residency situation was actually far more dire than what currently exists. This podiatrist did not obtain a residency program. Now what; all dressed up with no place to go. The podiatrist searched for a preceptorship and found one in St. Louis, MO under the guidance of Drs. Michael Figura and Sanford Postar. The pay was rotten, but it was a life preserver. This podiatrist contacted one of our visionary podiatrists, Dr. Arthur Helfand, and was able to setup the preceptorship in such a manner that it became approved by the Pennsylvania College of Podiatric Medicine.

The dream was still alive. In fact, it was better than expected. Dr. Figura was an accomplished podiatric surgeon and educator who performed all kinds of forefoot, midfoot, and rearfoot surgeries. Dr. Postar was similar to “Mr. Wonderful” on the television show, Shark Tank: he could account for every dollar ever earned and loved money. Wow, an opportunity to further one’s education and learn how to run an office. Shortly thereafter, he became a residency director of a PSR-12 program. He went on to become an oral examiner for both the ABPS and the ABPM. He then became residency director at another hospital and converted the then current two year program to one of the first PM&S-36 programs. Could this be happening? He then became a CPME onsite residency reviewer for the ABPS and ABPM. This was to be followed by election to the Board of Directors of the ABPM where he became Vice President. Now he is the editor of the ABPM Resident Newsletter. As the eloquent sportscaster Al Michaels said during a glorious US victory over the Russian National Team at the Olympics; “Do you believe in Miracles - Yes!”. Life is funny. People helped me and I have tried to help others. Paying it forward. Obstacles can be overcome if we work together to help one another. Rarely does one achieve it by themselves.
Previous professional care provided by orthopedic surgeons, physiatrists, physical therapists, and podiatrists did not definitively relieve his discomfort. Management included steroid injections, PRP injections, night splints, NSAID’s, CAM walker, orthotic devices, slant board stretching. Jerry had 3 PRP injections performed at a major New York City Hospital. The treating doctor asked Jerry how he was coming along and his reply was “I was at 0% when I started this painful process and I’m still at 0%.”

His current carbon-graphite composite devices were fabricated only one year ago, but Jerry stated that he hadn’t seen that doctor for many years. Upon further questioning, I discovered that these devices were made from a neutral subtalar positive plaster impression cast molded 18 years ago! Jerry had been religiously stretching his plantar fascia and Achilles complex for many years and had recently added a slant board to his routine.

Physical examination revealed an absence of visible inflammation at the site of the chief concern, lack of palpable tenderness along the plantar fascial course, except at its medial tubercle origins with a (+) 7-8/10 left and (+)6/10 right. The orthoses did not conform to pedal morphology. The vascular and neurologic parameters were found to be well within normal ranges.
# MUSCULOSKELETAL BIOMECHANICAL:

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MY DIAGNOSES INCLUDED:

- Proximal Plantar Fasciitis bilaterally, Left > Right
- Collapsed Cavus bilaterally
- Partially Compensated Rearfoot Varus bilaterally
- Compensated Forefoot Varus bilaterally
- Compensated Forefoot Equinus bilaterally
- Genu Recurvatum bilaterally
- Markedly Limited Internal Hip Rotations bilaterally
- Limb Length Discrepancy, Right > Left
- Hallux Flexus bilaterally

Weightbearing radiographs of both feet, as well as observational and computer assisted gait analysis, confirmed the above impressions. The presence of an inferior calcaneal spur, right greater than left, was also identified radiographically. The gait analysis revealed a premature heel lift bilaterally.

Barefoot computer assisted gait analysis (CAGA) revealed a short center of force pathway (COF) on the left and normal on the right. Increased pressure on the left calcaneus and the 2,3,4 metatarsal heads on the right was noted. Active propulsion was 21 left, 13 right. Single support, time, solitary limb support were equal however midstance was 33% right and 27% left (norm up to 30%) (CAGA) with Nike sneakers revealed a limb length discrepancy evidenced by calcaneal stance duration 13% greater on the left side, and increased left midstance phase 37% to 30% on the right, and propulsion increased on the right side 20% versus 14% left side.

MY INITIAL MANAGEMENT INCLUDED:

1. neutral subtalar plaster impression casting
2. weight dispersive rest strapping without longitudinal arch pad left
3. continuance of current orthoses
4. heel raises
5. counsel on footwear (discard present ones)
6. discontinue slant board and all other posterior group stretching
7. avoidance of barefoot walking
8. continue night splint
9. hip internal rotation exercises

I had also considered adjunctive NSAID therapy as well as steroidal injection, but Jerry refused. He indicated that he had tried those therapies previously without success. He stated that due to his knowledge of mechanics as a car aficionado, he preferred to try a biomechanical approach instead.

At his subsequent visit 9 days later, when I asked Jerry how he was doing his response was “Excellent. 100%”. I dispensed his orthoses consisting of carbon graphite composite for daily use and high density polyethylene for activity participation. Hip rotations were still severely restricted.

A follow-up gait analysis was performed two weeks later with the patient still at 100% comfort level. During Nike Sport orthotic walking with CAGA, excellent symmetry and waveforms were noted with active propulsion 26 left, 22 right.

Since the patient wears Nike sneakers for daily use, they were tested with the graphite composite devices and revealed a reduced midstance phase 21 left, 23 right and increased active propulsion 34 left, 32 right with all other parameters being symmetrical as well. Mild increased pressure sub 2nd metatarsal head was noted bilaterally primarily because these devices ended at the metatarsal heads, unlike the sports devices in which the correction was extended to the sulcus and then a soft tissue supplement to the toes was added.

THE HIP INTERNAL ROTATIONS WERE NOT IMPROVED.

One month later the patient was still at the 100% comfort level and wearing his orthoses whenever weight-bearing. The hip rotations were not improved and I suggested that he return to his physical therapist for management. Upon palpation of the area of chief concern there was still noted +7/10 tenderness bilaterally.

Two months later, with the patient still at 100% comfort level and “doing great”, there was only +3 tenderness noted at the medial calcaneal sites. Jerry told me “this has completely changed my life”. So why after 30 years did his heel pain resolve? Maybe I was just the right doctor at the right time who took a little more time, did a little more analysis. Maybe it was just a combination of factors, but in any case, what I did was something that any one of us could have done.

Heel Pain continued ~
I realize that this may sound egocentric. Here I am, some “old timer” (Geez, I hate that thought!) in podiatric medicine trying to impart some words of wisdom to the next generation. But, it has been almost 32 years since I graduated from SCPM and by most all accounts and measures I believe I have been pretty successful. So, I ask that you please indulge me in this folly.

I attribute whatever success I have in podiatric medicine to two principles I followed early in my career and have not regretted:

1. Think outside the box
2. Find an appropriate mentor

Neither of these amounts to a huge revelation. You may have heard variations of these principles from others. Yet, it seems that many do not heed the advice. Allow me to expound on how each of these played a major role in my professional development.

**THINK OUTSIDE THE BOX**

When I graduated SCPM in 1982 I envisioned a career that would follow the path of every podiatric student at that time. We all came into school enamored with the thought of being a surgeon! We had visions of walking into the operating room, having nurses glove us while the patient lay prepped on the table. It was a glamorous dream encouraged by our faculty. At Scholl we prided ourselves on graduating with more cases under our belts than graduates from any other college of podiatric medicine. There was a mad scramble for one of the few surgical residency spots that were available. You may think that there is a residency crisis now, and I agree that there is, but back in the early 1980s only 50% or fewer of graduates actually served a residency. If you were one of the unlucky that did not match, you hoped for a “preceptorship” where you could perhaps learn a few surgical procedures while working with a practicing DPM but were otherwise afraid you would be relegated to a life of primary podiatric care. The day of the match I was at an externship at the Westside VA hospital in Chicago. Of all of the students on rotation that month I was the only one who matched. Not only that, I had matched with one of the few two year surgical programs available at that time and it was back in my hometown of Philadelphia. I was set. My career path was firmly established!
My residency at St. Joseph Hospital was a revelation. I was one of four 1st years, two of whom were PCPM (now TUSPM) graduates and one from the NYCPM. We had a very mixed bag of second year residents and a few attendings who, frankly, made our lives a bit of a living hell. If your attendings even tried to pull a quarter of the stuff foisted on us you would probably be in the Administration office threatening a lawsuit! It was a different time and place. Despite these trials, I discovered I was becoming a pretty decent, if not gifted, podiatric surgeon.

We were fortunate to have some excellent medical and general surgical rotations. The Infectious Diseases service at the hospital was covered by the ID group from Hahnemann University Hospital and chaired by Jack LeFrock, MD, a well recognized specialist in the area of diabetic foot infections. I looked forward to rounding with Dr. LeFrock since I really felt I graduated school knowing absolutely nothing about antibiotic therapy and, possibly more important at the time to a poor resident (we were paid $2500/yr and were told by our DPM attendings that this was too much and we should be paying them for the privilege of learning from them), Dr. LeFrock always bought us lunch. One day late in my first year/beginning of my second, as we were eating, Dr. LeFrock casually mentioned to me that he felt that I had an interest in ID and asked me if I was interested in spending a year with them at Hahnemann as an ID Fellow. As he would later state in his inimitable fashion: “If you podiatrists are going to be treating diabetic foot infections you better damn well know HOW to do it right!”

“If you podiatrists are going to be treating diabetic foot infections you better know HOW to do it right!”

This was new and groundbreaking. No podiatrist had ever served a medical ID fellowship. In fact, the entire concept of fellowship training in podiatry was relatively unheard of at the time. My mouth hit the table. I thanked him for the offer and impulsively accepted immediately. Only then did the questions come: What was I doing? Would I be paid? If not, how would I live? Would I be accepted at a major university medical school/teaching hospital? Would my fellowship be recognized by our profession? I was venturing into totally unexplored professional territory. My first stop was to my parents. I explained the situation including the unknown question of a salary. They were enthusiastic and immediately supported my decision. They figured they had supported me for this long, what was another year. I then spoke to one of my favorite podiatric surgical attendings, a man who is still considered one of the all time great foot surgeons. His response was sobering: “Doctor, you are a surgeon, why would you possibly want to do an ID fellowship? How are you ever going to make a living?”

Finally, I visited the APMA Headquarters to meet with the Director of Scientific Affairs whom I had known and greatly respected when he was Dean of the Scholl College. I explained the fellowship offer and asked if there was any way that the APMA could “recognize” it. Although he had to tell me that there was no pathway available for official APMA recognition of the training, he strongly urged me to accept.

The rest, so they say, is history. Not only did I serve the fellowship at Hahnemann, I even received the stipend of a medical PGY III at a livable $25,000. The decision to accept the offer of the ID fellowship despite the dire predictions of my surgical attending changed my life both professionally and personally. It has defined my career despite it being a pathway that I would have never imagined while applying for surgical residencies during my 4th year of school.

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Having been involved with student and resident education my entire career, one of my great satisfactions comes from having someone I helped train come up to me, usually years later, and thank me for what I taught them and how they never appreciated it back while they were in school or residency. To know that I have a positive influence in somebody’s life is why I have always taught. This drive to help the next generation comes from my good fortune of having two exceptional role models/mentors who pushed, supported and directed me early on in my professional development. Without either of them I would not have become who I am today and I am certain my career would have taken an entirely different course.

The first is the aforementioned Dr. LeFrock. He saw the need to train a DPM in ID and didn’t let obstacles stand in his way. In order to get my fellowship approved at Hahnemann he faced negativity at every turn. He was told by the Chief of Orthopedics, a well known podiatry opponent and very powerful force within the hospital that “This is a medical school, we don’t train podiatrists here”. Even members of his own ID division were not enthused and gave major push-back. It took him close to a year of fighting, but he eventually went to the President of the University to plead the case. Only then, with the President’s blessing was the fellowship approved. Dr. LeFrock lived by the pledge that if he gave me his word, as he did by inviting me to work with him, he would not back down.

During the fellowship I was approached by the Chairman of Medicine at PCPM, Harvey Lemont, DPM about joining the Department at the college. He had a vision, unique at the time that “Podiatric Medicine”, defined at most of the colleges and by the profession as the treatment of corns, nails and calluses, was actually a true specialty consisting of dermatology, neurology, ID, radiology, rheumatology, vascular medicine, etc. Having trained in pathology he was building a Department of fellowship trained specialists. I signed on to that vision and that position. Dr. Lemont was my Chair for most of my 15 years at the PCPM/TUSPM. During that time he gave me the freedom to build the specialty of podiatric infectious diseases. He funded me to go to major ID conferences. Whenever I requested a book or journal subscription he found the monies for it. He saw the importance of training the profession in ID and gave me the time to attend podiatric CME meetings and lecture throughout the country. In return he expected production in terms of publications and teaching of the students. This was not a free ride. If not for Dr. Lemont I would not have been able to take the base of knowledge I gained from Dr. LeFrock and build on it to be the specialist I am today.

I know that this is a lot about me. You can’t say I didn’t warn you up front! I hope that by sharing my story it may better enable you to think about the future with a different perspective. If you are satisfied with the way your training and future career are heading, congratulations and my best wishes to you. However, if you want something a bit unique and want to consider the “road less traveled”, then please let this story be at least some inspiration to you. You have options.
RESIDENTS:

1. What is the ABPM?
The American Board of Podiatric Medicine (ABPM) is the only board recognized by the Joint Committee on the Recognition of Specialty Boards of the Council on Podiatric Medical Education under the authority of the American Podiatric Medical Association to certify in podiatric orthopedics and primary podiatric medicine.

2. What are the benefits of being Board Certified by ABPM?
• New practicing podiatric physicians can attain ABPM certification shortly after completing residency, versus waiting for surgical certification, which can take up to seven years.
• Physicians who have completed an accredited three-year residency program can move quickly from board qualification to board certification, bypassing the traditional case-gathering process.
• This means physicians looking to become ABPM certified podiatrists may be able to do so the year in which they complete their residency program.

3. What is the In-training Exam?
While in residency, your Director may sign you up for the ABPM In-training Examination. The In-training exam consists of 200 short answer questions. After the exam is over, those that were registered will have access to the questions and answers and suggested readings to assist in preparing for the ABPM Board exams.

4. Where can I get yet more information?
Please visit our website at www.ABPMed.org and be sure to like us on Facebook (American Board of Podiatric Medicine - ABPM), and follow us on Twitter (ABPMed) and LinkedIn (ABPM-American-Board-Podiatric-Medicine) for ongoing reminders about test dates, events, etc.

EXAM RELATED:

1. What are the dates of the 2014 exams?
The ABPM Board Qualification Examination is Friday, June 6, 2014.
The ABPM Board Certification Examination is Friday, October 3, 2014.
Applications were due postmarked by March 15, 2014.
Both exams are offered at Prometric Testing Centers Nationally.

2. What are the requirements to be eligible to apply for the Board Examinations?
• Applicants who have completed a minimum of 36 months of CPME-approved training (PMSR, PM&S-36, PM&S-24 + PPMR or POR) are no longer required to submit case documentation as a pre-requisite to the certification examination.
• Applicants with 24 months of CPME-approved training (PM&S-24, or other inclusive of PPMR or POR program) are still required to submit case documentation and pass the case review process for admission to the certification examination.
• A RPR/PSR training sequence does not fulfill the criteria for application.
• Applicants must have passed the board qualification examination and be currently board qualified with ABPM prior to sitting for the board certification exam.

3. Is there a limit as to how long after residency I can sit for the Exam?
No, as long as you have the requirements eligible to sit in the current year you wish to submit an application, you can apply for board qualification or certification.

4. What do I submit with my application?
• Copy of your state podiatry license
• Copy of your certificate of completion from residency

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The American Board of Podiatric Medicine
RESIDENT NEWSLETTER

Frequently Asked Questions continued ~

• If you are currently in residency, then we require a letter from your Residency Director indicating the type of residency you are in and when you are due to complete it
• Appropriate fees

5. Which application do I submit?
Applicants who wish to sit for both the qualification and certification exam in the same year (2014), must submit form 104.
Applicants who wish to sit for board qualification only, may submit form 103.

6. What happens if I don’t pass the qualification exam and have submitted form 104?
Applicants who submit form 104 with the intention to sit for board qualification and certification in the same year and do not pass the qualification exam in June will receive a partial refund.

7. How long does board qualified status last?
Board qualification status is active up to 5 years. Candidates may sit as many times as they wish but if they do not become board certified by their 5th year, their board qualification status expires and they may begin again as long as they are eligible during the year they are submitting an application.

MEMBERS:

1. How do I access my personal information on the Website?
You may access your personal information by clicking the “Members Dashboard” and logging in using your own user name and password.

2. What is my user name and password?
User name and password can be found on the dues statement or by contacting board headquarters at 310.375.0700.

3. What do I do when my address has changed?
If your address has changed, you may fax or e-mail the information to admin@ABPMed.org. You may also input current information onto the website by accessing the “members dashboard”. Please note, only one address is allowed. Whatever address is in our system will also appear in the public search option on our website.

4. When are the annual registration fees (dues) required?
Initial notices were mailed out in January 2014 and dues received after March 20, 2014 are subject to a late fee. You may go on-line and log in at the Members Dashboard to view the information we currently have on file for you.

5. Does ABPM offer discounted registration fees?
The ABPM does not extend discounted fees for Board Qualified or Board Certified members, whether in full-time or part-time practice, with the following exception: Beginning in 2007, Founder and Emeritus members less than 65 years of age but with 25 years of membership or more receive a reduction in annual re-registration fees. If a member is no longer deriving income from Podiatry (i.e. retired or inactive) and can provide the Board with documentation to that affect, they may be exempt from paying re-registration fees.

6. How do I pay my dues?
• You may pay dues using a credit card on our website by accessing the “members dashboard” from the members page. Your personal password and user name can be found on the dues statement. You will be required to create a more secure password once you are logged in.
• Or, you may pay by mailing in a check along with a copy of the dues statement to ABPM.
ABPM WAIVES CASE SUBMISSION REQUIREMENT
for Certification Examination

By Marc A. Benard, DPM, ABPM Executive Director

Residents who have completed PMSR, PM&S-36, or PM&S-24 plus PPMR residency programs will no longer be required to submit case documentation as a precursor to the certification examination. Graduating residents and former residents who completed the above program types and pass the ABPM qualification examination may sit for the 2014 certification examination in October. Older residency training sequences (e.g. PSR/PPMR/POR combinations) meeting the 36 month training requirement are also subject to the waiver. Training must include PPMR or POR residency types. If you have additional questions, please visit our website at www.ABPMed.org or contact the headquarter office at Admin@ABPMed.org

LOOK FOR ABPM AT UPCOMING CONFERENCES

April 3-6, 2014 | Midwest Podiatry Conference | Hyatt Regency, Chicago, IL | Join us Friday for a Hosted Reception

May 30-June 1, 2014 | Residency Education Summit MidWest | Oakbrook Hills Marriott, Oak Brook, IL

July 24-27, 2014 | APMA Scientific Meeting | Hawaii Convention Center, Honolulu, HI | Join us Friday for a Hosted Reception

August 15-17, 2014 | Residency Education Summit East | Teaneck, NJ

September 11-13, 2014 | Superbones West | Cosmopolitan, Las Vegas, NV

November 19-21, 2014 | Desert Foot Conference | Sheraton Phoenix Downtown, Phoenix, AZ