



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

**BOARD OF MEDICAL LICENSURE AND DISCIPLINE**

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: [DPR.DELAWARE.GOV](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@state.de.us](mailto:customerservice.dpr@state.de.us)

**APPLICATION FOR LICENSURE AS AN ACUPUNCTURE OR EASTERN MEDICINE PRACTITIONER  
INSTRUCTION SHEET**

Please read all instructions carefully before completing and submitting your application. If your application is not complete within six months of filing, it may be considered abandoned and discarded.

**Type of Application**

The documentation that you are required to submit in support of your application depends in part on which type of application you are filing. Use these guidelines to identify the type of application:

- **Acupuncture Practitioner** – Select this license if you have earned a Diplomate in Acupuncture from the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) or an equivalent organization.
- **Eastern Medicine Practitioner** – Select this license if you have earned a Diplomate in Oriental Medicine from the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) or an equivalent organization. The Acupuncture Advisory Council may waive this Diplomate requirement under specific circumstances as outlined in [24 Del. C. §1798 \(c\)](#). See the **Requirements for All Applicants** section below.

IF you...	THEN apply by...
do not hold a current license of the same type in another jurisdiction (state, D.C. or U.S. territory)	Original License
<ul style="list-style-type: none"> <li>• hold a <i>current</i> license of the same type in another jurisdiction (state, D.C. or U.S. territory), <b>and</b></li> <li>• a jurisdiction where you hold a current license has licensing requirements that are at least equal to Delaware's requirements, <b>and</b></li> <li>• no outstanding or unresolved complaints are pending against you</li> </ul> <p>You can be licensed by reciprocity only if you meet all three requirements. For example, if the Council determines that no jurisdiction where you hold a current license has licensure requirements equal to those of Delaware, you would have to meet the requirements for original licensure, instead of reciprocity.</p>	Reciprocity.

**Requirements for All Applicants**

The following summarizes the documentation requirements for all applicants. The application form may request additional documentation based on your answers to the questions.

- Submit completed, signed and notarized [Application for Licensure as an Acupuncture or Eastern Medicine Practitioner](#).
  - Make sure all questions are answered unless the instructions tell you to skip a question.
  - Read the AFFIDAVIT section.
  - Sign the application in front of a notary public.
  - Forms that are incomplete, unsigned or not notarized will be rejected.
- Enclose the non-refundable [processing fee](#) by check or money order made payable to "State of Delaware."
  - If you hold a *current* Delaware Acupuncture license and are applying to upgrade to an Eastern Medicine Practitioner license, enclose the [upgrade fee](#) instead of the full processing fee.
  - Applications submitted without a fee will be rejected.

- Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.
  - You must meet this requirement *even if* you recently had a criminal background check done for some other reason.
- If English is **not** your first language, submit proof that you passed the [Test of English as a Foreign Language \(TOEFL\)](#) with a minimum score of 550, or any other method in Section 4.2.1 of [Rules and Regulations](#).
- Submit proof of your eastern medicine/acupuncture education as follows:

IF you are applying for...	AND IF you...	THEN arrange for the Board office to receive verification of your:
Acupuncture Practitioner	--	Diplomate in Acupuncture from the NCCAOM or an equivalent organization.
Eastern Medicine Practitioner	have a Diplomate in Oriental Medicine	Diplomate in Oriental Medicine from the NCCAOM or an equivalent organization.
	do <b>not</b> have a Diplomate in Oriental Medicine	Education in acupuncture or eastern medicine sent <i>directly</i> from the educational institution to the Board office. The Council will determine if the Diplomate requirement may be waived under specific circumstances as outlined in <a href="#">24 Del.C. §1798 (c)</a> .

- Complete, sign and submit the *Delaware Child Protection Registry Request Form* to the Department of Services for Children, Youth & Their Families following the instructions on the form.
- Arrange for the Board office to receive a certificate verifying that you have completed a course or passed an examination in clean needle technique (CNT), sent directly from NCCAOM to the Board office.
  - If CNT was completed before 1990 as part of the NCCA (predecessor of the NCCAOM) exam in acupuncture, the NCCA certification in acupuncture (achieved in 1990 or before) will be accepted in lieu of the above mentioned course certificate.
  - To request this verification from NCCAOM, complete the [Clean Needle Technique Certificate/Verification Request Form](#) available on [www.ccaom.org](http://www.ccaom.org). Click "Clean Needle Technique Course" and then "Certificate/Verification Request."
- If you have ever been licensed to practice acupuncture or eastern medicine in another jurisdiction (state, U.S. territory or District of Columbia), arrange for a letter of good standing to be sent to the Board *directly* from *each* jurisdiction where you hold, or have ever held, an acupuncture or eastern medicine practitioner license.
  - The jurisdiction's seal must be affixed to the verification. Internet or faxed verifications will not be accepted.
- If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).  
*The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

**Additional Requirement for Reciprocity Applicants**

- Submit copies of the licensing/practice statutes and regulations pertaining to the practice of acupuncture or eastern medicine from each jurisdiction where you are currently licensed.
  - The Council will determine whether the licensing requirements of any of the jurisdiction(s) are substantially equivalent to those of Delaware.



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## APPLICATION FOR LICENSURE AS AN ACUPUNCTURE OR EASTERN MEDICINE PRACTITIONER

### TYPE OF APPLICATION

1. Select the type of license you applying for (check one):

- Acupuncture Practitioner – I currently hold a Diplomate in Acupuncture from NCCAOM or an equivalent organization. Skip to Question 3.
- Eastern Medicine Practitioner – I currently hold a Diplomate in Oriental Medicine from NCCAOM or an equivalent organization. (The Acupuncture Advisory Council may waive this Diplomate requirement under specific circumstances as outlined in [24 Del. C. §1798 \(c\)](#).) Continue with Question 2.

2. Do you hold an **active** Delaware Acupuncture Practitioner license and wish to **upgrade** to an Eastern Medicine Practitioner license? Yes  No

- If yes, enter your Acupuncture Practitioner license number: CT- \_\_\_\_\_ . Skip to the IDENTIFYING AND CONTACT INFORMATION section.
- If no, continue with Question 3.

3. Check the item that describes your situation (check one):

- Original Licensure
- Reciprocity – See Instruction Sheet for requirements to apply by reciprocity.

**Submit copies of the licensing/practice statutes and regulations pertaining to the practice of acupuncture or eastern medicine from the jurisdiction(s) where you hold a current license.**

### IDENTIFYING AND CONTACT INFORMATION

4. Full Name: \_\_\_\_\_  
Last First Middle

5. Other Names Used: \_\_\_\_\_ None   
Include maiden, former married, alternate spellings.

6. Date of Birth (month/day/year): \_\_\_\_\_ Gender: Male  Female

7. Have you been issued a U.S. Social Security Number? Yes  No  **If yes, enter your SSN:** \_\_\_\_\_  
**If no, you must file a [Request for Exemption from Social Security Number Requirement](#).**

8. Mailing Address: \_\_\_\_\_  
City State Zip

9. Phone: \_\_\_\_\_ daytime or cell \_\_\_\_\_ fax Email: \_\_\_\_\_ None

### EDUCATION & CERTIFICATION INFORMATION

10. Is English your first language? Yes  No  **If no, submit proof that you passed the [Test of English as a Foreign Language \(TOEFL\)](#) with a minimum score of 550, or any other method in Section 4.2.1 of the [Rules and Regulations](#).**

11. Have you successfully completed a course or passed an examination in clean needle technique (CNT)?  
 Yes  No  **If yes, arrange for the Board office to receive a certificate verifying that you have completed a CNT course or passed a CNT examination), sent directly from NCCAOM to the Board office.**
12. Are you applying for Acupuncture Practitioner? Yes  No  **If yes, arrange for the Board office to receive verification of your Diplomate in Acupuncture *directly* from the organization. Skip to the INFORMATION ABOUT LICENSURE & PRACTICE section.**
13. Do you hold a Diplomate in *Oriental Medicine* from NCCAOM or equivalent organization? Yes  No  **If yes, arrange for the Board office to receive verification of your Diplomate *directly* from the organization. Skip to the INFORMATION ABOUT LICENSURE & PRACTICE section.**
14. Enter the following information about your acupuncture or eastern medicine practitioner education.

SCHOOL/TRAINING	LOCATION	DATES ATTENDED		DEGREE
		From	To	

Arrange for the Board office to receive verification of this education sent *directly* from the educational institution to the Board office. The Council will determine if the Diplomate requirement may be waived ([24 Del. C. §1798 \(c\)](#)).

**INFORMATION ABOUT LICENSURE & PRACTICE**

15. Are any disciplinary actions or complaints pending against you before any body that regulates the practice of acupuncture? Yes  No  **If yes, on a separate sheet, identify where the action is pending, describe the complaint/action, and include the anticipated date of resolution, if known. Enclose the sheet with the application.**
16. Have you ever had an acupuncture or eastern medicine practitioner license denied, revoked, suspended or limited or placed on probation? Yes  No  **If yes, explain on a separate sheet and enclose with this application. Also, enclose a copy of the disciplinary order.**
17. Do you now hold, or have you ever held, a license as an acupuncture or eastern medicine practitioner in any jurisdiction (state, District of Columbia, or U.S. territory)? Yes  No  **If yes, enter information about your licenses:**

JURISDICTION	TYPE OF LICENSE (Eastern Medicine or Acupuncture)	LICENSE NUMBER	EXPIRATION DATE

Arrange for a “letter of good standing” to be sent to the Board *directly* from *each* jurisdiction where you have ever held an acupuncture or eastern medicine practitioner license.

**HEALTH AND DISABILITY**

18. Within the two years preceding this application, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as an acupuncture or eastern medicine practitioner, including use or abuse of dangerous or addicting substances? Yes  No
- **If yes, explain on a separate sheet and enclose with this application.** Continue with the next question.
  - If no, skip to the DISCLOSURES section.
19. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes  No  **If yes, explain on a separate sheet and enclose with this application.**

## DISCLOSURES

20. Have you ever been convicted or entered a plea of guilty or *nolo contendere* (no contest) to any felony or misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes  No  **If yes, submit a signed statement explaining fully.**

**Arrange for the Council office to receive State of Delaware and Federal Bureau of Investigation criminal background checks.**

21. Are any criminal charges pending against you in any jurisdiction? Yes  No  **If yes, submit a signed statement explaining fully.**
22. Have you ever been disciplined by a healthcare facility or any entity governing acupuncture or eastern medicine practitioner licensure? Yes  No  **If yes, explain on a separate sheet and enclose it with this application. Also, enclose a copy of the disciplinary action.**
23. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes  No  **If yes, provide a copy of any documents in your possession related to the final disposition of the investigation and continue with the next question.** If no, skip to the DUTY TO REPORT section.
24. Do you agree to sign an authorization for the Board of Medical Licensure and Discipline and the Division of Professional Regulation to obtain any and all information concerning the disposition of the investigation directly from the licensing authority, medical association, hospital or other healthcare institution? Yes  No

## DUTY TO REPORT

25. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 Del. C. §1731 OR that he/she is (or may be):
- medically incompetent
  - mentally or physically unable to engage safely in the practice of medicine
  - excessively using or abusing drugs including alcohol.

I certify that I have read and understand the provisions of [24 Del. C. §1730](#), [24 Del. C. §1731](#) and [24 Del. C. §1731A](#) and that I understand my *duty to report*. Yes  No

26. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

I certify that I have read and understand [16 Del. C. §903](#) and that I understand my *duty to report*. Yes  No

**Complete, sign and submit the Delaware Child Protection Registry Request Form to the Department of Services for Children, Youth & Their Families following the instructions on the form.**

27. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to self report all of the following:
- Any change in hospital allied healthcare privileges and any disciplinary action taken by any medical society against you within 30 days (24 Del. C. §1730(b)(1))
  - Any civil or criminal investigation in any jurisdiction which concerns your certification or license or other authorization to practice medicine within 30 days (24 Del. C. §1730(b)(2))
  - All information concerning medical malpractice claims settled or adjudicated to final judgment, as provided in Chapter 68 of Title 18, within 60 days. (24 Del. C. §1730 (c))
  - Each final judgment, settlement, or award against you regardless whether you have malpractice insurance, within 30 days of the final judgment, settlement, or award. (24 Del. C. §1731A (f))
  - Any reports filed against you with the Department of Services for Children, Youth and Their Families under Chapter 9 of Title 16 concerning child abuse or neglect (24 Del. C. §1730 (d))
  - Any reports filed against you to the Division of Long Term Care Residents Protection under Chapter 85 of Title 11 concerning adult abuse, neglect, mistreatment or financial exploitation (24 Del. C. §1730 (d))

I certify that I have read and understand all of provisions in the [Delaware Medical Practice Act](#), including those listed above, and understand my *duty to self report*. Yes  No

The Board office must receive all of these items no later than 4:30 PM ten full working days before the Council's next meeting date in the event that your application requires the Council's review:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

**AFFIDAVIT**

I swear all of the following:

- I am the person who executed this application.
- The statements contained on this application are true in every respect.
- I have not suppressed or withheld information that might affect this application.
- I will abide by the laws and the ethical standards of this profession.
- I have read and understand this statement.

I further understand that by filing this application for an Acupuncture or Eastern Medicine Practitioner in the State of Delaware, I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in 24 Del. C. §1731 or the Board of Medical Licensure and Discipline and Council's Rules and Regulations and to determine that I am physically and mentally capable of engaging in the practice of acupuncture with safety to the public.

I authorize the Council of the Board of Medical Licensure and Discipline and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Board of Medical Licensure and Discipline any such information, including document, records regarding charges or complaints filed against me, formal or informal, pending or closed, other pertinent data and to permit the Board of Medical Licensure and Discipline or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

I understand and acknowledge that the Council of the Delaware Board of Medical Licensure and Discipline will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to

- Keep the information in this application current until such time as the Board has finally acted on it, and
- Promptly provide any and all additional information requested by or on behalf of the Board.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

City of \_\_\_\_\_ County of \_\_\_\_\_

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

Signature of Notary: \_\_\_\_\_

SEAL

My Commission Expires: \_\_\_\_\_

**APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.**

# Instructions for Requesting a Criminal Background Check

**Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.**

## Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See [Title 28, CFR 16.34](#) for the procedure to obtain a change, correction or update in the FBI record.

## Locations

### **Kent County – Primary Facility**

State Bureau of Identification  
Blue Hen Mall & Corporate Center  
655 S. Bay Rd. Suite 1B  
Dover, DE 19901

**Walk-ins accepted:** Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm  
Customer Service: (302) 739-2134

### **New Castle County - Satellite Facility**

State Police Troop Two  
100 LaGrange Ave  
Newark, DE 19702  
(between Rts. 72 and 896 on Rt. 40)

**By appointment only**  
Scheduling: (302) 739-2528 (local)  
(800) 464-4357 (toll free)

### **Sussex County – Satellite Facility**

Thurman Adams State Service Center  
546 S. Bedford Street, Rm. 202  
Georgetown DE 19947  
(across from DelDOT & Troop 4)

**By appointment only**  
Scheduling: (302) 739-2528 (local)  
(800) 464-4357 (toll free)

## Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. **Personal checks are not accepted in any county.** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

## Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a [FD-258 fingerprint form](#) available on the FBI website at [www.fbi.gov](http://www.fbi.gov) – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.
2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.
3. **Mail** the *Authorization* form, fingerprint card, and *certified* check or money order (**personal checks are not accepted**) for \$65.00 made payable to “Delaware State Police” to:

**Delaware State Police  
State Bureau of Identification (SBI)  
PO Box 430  
Dover, DE 19903-0430**

**DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.  
DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.**

**⇒ ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.**





# DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM



Fax or Mail Request to: OCCL, Criminal History Unit  
 Concord Plaza, Hagley Building  
 3411 Silverside Road  
 Wilmington, DE 19810  
 Phone: 302-892-5800 Fax: 302-633-5191

When requesting Child Protection Registry checks:

- **Allow 15 working days for results to be processed.**
- **Do not use a cover sheet.**
- **Do not send duplicate requests.**
- **Form must be submitted to DSCYF within 90 days of signature date in order to be processed.**

## PART I. APPLICANT INFORMATION – Type or print clearly.

Name: \_\_\_\_\_  
Last First Middle

Other Name(s) Used: \_\_\_\_\_ DE Drivers License #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: Male  Female:  Race: \_\_\_\_\_  
mm / dd / yyyy

Address: \_\_\_\_\_  
Street City State Zip

Have you ever been involved in a substantiated case of child abuse or neglect? Yes  No  If Yes, explain:  
 \_\_\_\_\_  
 \_\_\_\_\_

I hereby authorize The Delaware Department of Services for Children, Youth and Their Families to provide the below named agency/organization with all substantiated cases of child abuse or neglect concerning me contained in the Child Protection Registry. I further release the Delaware Department of Services for Children, Youth and Their Families, its officers and employees from any and all claims arising out of or in any way connected to the release or dissemination of any information concerning me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature if applicant is under the age of 18: \_\_\_\_\_

## PART II. AGENCY/ORGANIZATION INFORMATION

<b>Please check only <u>one</u>:</b>			
<input type="checkbox"/> EDUCATION	<input type="checkbox"/> HEALTH CARE FACILITY	<input type="checkbox"/> CHILD CARE	<input checked="" type="checkbox"/> OTHER: <u>State Agency</u>

Agency Identification Number (if applicable): 1179  
 Requesting Agency Name: **Division of Professional Regulation**  
 Address: Cannon Building, 861 Silver Lake Boulevard, Suite 203, Dover, DE 19904  
 Phone: (302) 744-4500 Fax: (302) 739-2711 Contact Person: Nicole Williams

<b>DSCYF USE ONLY</b>	
The individual listed above ( ___ is listed) ( ___ is NOT listed) on the Delaware Child Protection Registry.	
Date: _____	DSCYF Criminal History Unit _____