



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

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

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

APPLICATION FOR PHYSICIAN LICENSE TO PRACTICE MEDICINE AND SURGERY INSTRUCTION SHEET

Please read all instructions carefully before completing and submitting your application. Failing to follow instructions may delay your licensure. All auxiliary forms you need are included in this packet.

If your application is not complete within six months of filing, it may be considered abandoned and discarded.

Checklist for All Applicants

- Submit completed, signed and notarized [application](#) form.
 - 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.
- Enclose [processing fee](#) by check or money order made payable to "State of Delaware."
- Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the authorization 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 you *ever* held a medical or training license in any jurisdiction other than Delaware, arrange for the Board office to receive a *Verification of Physician License* form from *each* jurisdiction where you have held a license.
 - Before forwarding the form, check whether the jurisdiction requires a fee.
 - The Board office must receive the completed verification *directly* from the other jurisdiction. The jurisdiction's seal must be affixed to the form.
 - Internet verifications or faxed verifications will not be accepted.
- If you previously practiced medicine (other than as an intern, resident, fellow, or house physician), arrange for the Board office to receive a *Service Letter* from *each* healthcare facility where you currently have, or you had within the past five years, either direct patient access or admitting or staff privileges.
 - A responsible physician at the facility must sign the form.
 - The facility's institutional seal must be affixed to the form. If no seal is available, the completed form must be notarized.
 - Facilities must return the forms directly to the Board office within 10 days of receiving the request. Faxed forms will not be accepted.
- If any of the following describes your situation, arrange for the Board office to receive *two* letters of reference from physicians who are familiar with you but are not related to you:
 - You were self-employed for the entire past five years, or
 - You had *no* direct patient access during the past five years, or
 - One or more of the facilities where you had direct patient access in the past five years no longer exists.
- If you answer "yes" to questions in the DISCLOSURES section – other than Questions 31, 33, 34 – you must fully explain your answer. We suggest that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, submit a *signed, notarized statement* in lieu of or in addition to the *Physician Self-Report*.
- 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.

- Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Banks (NPDB/HIPDB) website at www.npdb-hipdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, mail (do not fax) the **original report** to the Board office.
- 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 FCVS Applicants

Delaware accepts the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards (FSMB). For more information, see www.fsmb.org/fcvs_physician.html.

- Arrange for the Board office to receive your Physician Information Profile from FCVS.

Additional Requirements Non-FCVS Applicants

If you are not using the FCVS service, the following requirements apply.

- Submit an 8 1/2" X 11" copy of your medical school diploma.
 - If you are a foreign medical graduate, attach an English translation from a reputable translating organization.
- Arrange for the Board office to receive a *Verification of Medical Education* from *each* medical school you attended.
 - The Board office must receive the completed form *directly* from each school. The school's seal must be affixed to the form. If no seal is available, the form must be notarized.
 - Internet verifications or faxed verifications will not be accepted.
- If you graduated from a foreign medical school, submit 8 1/2" X 11" copy of your current and valid Educational Commission for Foreign Medical Graduates (ECFMG) certificate.
- Submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s).
 - Only training programs are those that have been approved by the Accreditation Council for Graduate Medical Education will be accepted.
 - If you graduated from a program approved by the American Medical Association (AMA) or American Osteopathic Association (AOA) in the U.S. (or U.S. territory) or Canada, you must have completed one year of postgraduate training in the U.S.
 - If you did not graduate from an AMA- or AOA-approved program, you must have completed three years of postgraduate training in the U.S.
- Arrange for the Board office to receive a *Verification of Post Graduate Medical Education* form from *each* program that you attended.
 - The Board office must receive the completed verification *directly* from each program. The program's seal must be affixed to the form. If no seal is available, the form must be notarized.
 - Internet verifications or faxed verifications will not be accepted.
- Request a complete examination history, including all passing and failing attempts, sent *directly* to the Board office from the following organizations:
 - ECFMG – Request report at www.ecfm.org.
 - Federal Licensing Examination (FLEX), United States Medical Licensing Examination (USMLE), and Special Purpose Examination (SPEX) examinations administered by the Federation of State Medical Boards – Request report at www.fsmb.org.
 - National Board of Medical Examiners (NBME) examination administered by the National Board of Medical Examiners – Request report at www.nbme.org.
 - National Board of Osteopathic Medical Examiners (NBOME) Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) examinations administered by the National Board of Osteopathic Medical Examiners. Request report at www.nbome.org
 - Qualifying Examination (QE) Part I and Part II conducted by the Medical Council of Canada for the purpose of awarding the "Licentiate of the Medical Council of Canada" (LMCC). Request report at www.mcc.ca.

Personal Interview

A personal interview with a member of the Board is required for all Physician applicants. When your application has been reviewed, the Board office will notify you whom to contact to schedule your interview.

Controlled Substance Registration

- The application for Physician licensure is **NOT** an application for a controlled substance registration (CSR). For the CSR application and instructions, see [Application for Controlled Substances Registration – Practitioners](#).
- If you apply for your Physician license and CSR at the same time, the Controlled Substance application will be processed *after* your Physician license is issued. When your Delaware CSR is approved, you must then file for a [federal DEA registration](#).



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APPLICATION FOR PHYSICIAN LICENSE TO PRACTICE MEDICINE AND SURGERY

TYPE OF APPLICATION

1. I am applying for Physician licensure as a:

- MD – I received my medical education: in the U.S. outside the U.S.
 DO

2. Will you use the FCVS to provide your Physician Information Profile to the Board? Yes No

IDENTIFYING AND CONTACT INFORMATION

3. Full Name: _____
Last/Family First Middle

4. Other Names Used: _____

5. Date of Birth (month/day/year): _____ Gender: Male Female

6. Do you have 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](#).

7. Mailing Address: _____
City State Zip

8. Phone: _____ Home Work Email: _____

MEDICAL EDUCATION

9. Enter complete information about your medical education.

SCHOOL NAME	LOCATION	DATES ATTENDED	DEGREE RECEIVED

If you are not using FCVS, submit an 8 1/2" X 11" copy of your medical school diploma and arrange for the Board office to receive a *Verification of Medical Education* form from each medical school.

10. Did you graduate from a foreign medical school? Yes No If yes, enter your USMLE/ECFMG Identification Number: 0- _____ **If you are not using FCVS, submit 8 1/2" X 11" copy of your ECFMG certificate.**

POST-GRADUATE TRAINING

11. Enter **complete** information about your post-graduate training. **If you need more room, enclose a separate sheet with the same information.**

HOSPITAL/INSTITUTION	LOCATION	DATES OF TRAINING	SPECIALTY

If you are not using FCVS, submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s) and arrange for the Board office to receive *Verification of Post Graduate Medical Education* form from each program.

12. Enter information about your area/field of specialization.

AREA/FIELD	ARE YOU BOARD ELIGIBLE?	ARE YOU BOARD CERTIFIED?
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

EXAMINATION HISTORY

13. Check each examination that you have taken and enter the requested information about that exam.

- ECFMG (Basic) If passed, date: _____
- ECFMG (Clinical) If passed, date: _____
- ECFMG (English) If passed, date: _____

- Flex Component 1 If passed, date: _____
- Flex Component 2 If passed, date: _____
- Pre-1985 Flex If passed, date: _____

- USMLE Step 1 If passed, date: _____
- USMLE Step 2 If passed, date: _____
- USMLE Step 3 If passed, date: _____

- NBME Part 1 If passed, date: _____
- NBME Part 2 If passed, date: _____
- NBME Part 3 If passed, date: _____

- NBOME Part 1 If passed, date: _____
- NBOME Part 2 If passed, date: _____
- NBOME Part 3 If passed, date: _____

- SPEX If passed, date: _____

- COMLEX Level 1 If passed, date: _____
- COMLEX Level 2 If passed, date: _____
- COMLEX Level 3 If passed, date: _____

- LMCC If passed, date: _____
- State Board Examination State: _____ If passed, date: _____

If you are not using FCVS, arrange for Board office to receive complete examination histories, including all passing and failing attempts, from the organization.

LICENSURE HISTORY

14. Have you ever held a medical license issued by another jurisdiction (state, U.S. territory or District of Columbia)? Yes No If yes, list *each* jurisdiction where you now hold, or have ever held, a medical license, including training licenses.

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE

Arrange for the Board office to receive a *Verification of Physician License* form from each jurisdiction where you have held a license to practice medicine. This applies whether or not you are using FCVS.

PRACTICE HISTORY

15. Have you previously practiced medicine (other than as an intern, resident, fellow or house physician)? Yes No **If yes, continue with the next question. If no, arrange for the Board office to receive *two* letters of reference from physicians who are familiar with you but are not related to you AND skip to the DISCLOSURES section.**
16. Did you have any direct patient access during the past five years? Yes No **If no, arrange for the Board office to receive *two* letters of reference from physicians who are familiar with you but are not related to you AND skip to the DISCLOSURES section.**
17. Were you self-employed for the entire past five years? Yes No **If yes, arrange for the Board office to receive *two* letters of reference from physicians who are familiar with you but are not related to you AND skip to the DISCLOSURES section.**
18. List ***each*** healthcare facility where you currently have, **or** had within the past five years, either direct patient access or admitting or staff privileges. *If you need more room, enclose a separate sheet with the same information.*

FACILITY NAME	ADDRESS	AFFILIATION DATES		DOES THIS FACILITY STILL EXIST? Yes <input type="checkbox"/> No <input type="checkbox"/>
		From	To	
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>

Arrange for the Board office to receive a *Service Letter* from each listed healthcare facility that still exists. In addition, if any of the listed facilities no longer exists, arrange for the Board office to receive *two* letters of reference from physicians who are familiar with you but are not related to you.

DISCLOSURES

If you answer “yes” to questions in this section – other than Questions 31, 33, 34 – you must fully explain your answer. We suggest that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, submit a signed, notarized statement in lieu of or in addition the *Physician Self-Report*. Specify the jurisdiction where the incident occurred, the issues involved and any further information you wish to provide.

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

Arrange for the Board office to receive state and federal criminal background checks. This applies whether or not you are using FCVS.

20. Have you ever been professionally penalized or convicted of fraud? Yes No

21. Have you ever had a medical or professional license denied or revoked? Yes No

22. Have you ever violated the Medical Practice Act of another jurisdiction? Yes No

23. Have you ever been disciplined or had formal written action taken by a hospital staff or medical society, or licensing board of another jurisdiction? Your response should include any discipline or action taken during your training program including, but not limited to, academic probation. Yes No

Request a self-query from the NPDB/HIPDB and submit the *original report* to the Board office. This applies whether or not you are using FCVS.

24. Has a hospital, related health care facility, HMO, or alternative health care system ever:

- denied your application for privileges or failed to renew your privileges? Yes No
- limited, restricted, suspended, or revoked your privileges in any way (including during your training program)? Yes No

25. 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 Question 27.**

26. 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

27. Have any charges or complaints of any kind, including criminal charges and malpractice claims, ever been filed against you? (Include any that are *currently* pending against you.) Yes No

28. Have you ever engaged in the practice of medicine without a license? Yes No

29. Have you ever willfully violated the confidence of a patient? Yes No

30. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any of the following:

- administrative or judicial proceedings or investigation? Yes No
- inquiry or other proceeding? Yes No
- proposed termination by an educational institution, employer, governmental agency, professional organization, or licensing authority? Yes No

If yes to **any** item, continue with the next question. **If no to all, skip to Question 32.**

31. Are such current conditions or impairments reduced or ameliorated because of ongoing treatment (with or without medication) or participation in a monitoring program or because of the field of practice, the setting, or the manner in which you have chosen to practice medicine? Yes No

32. Do you have a mental or physical disability that limits your ability to practice medicine in a fully competent and professional manner with safety to patients? Yes No **If yes, continue with the next question. If no, skip to Question 34.**
33. Are you willing to accept a conditional or limited license to practice medicine if it is possible to accommodate such disability? Yes No
34. Do you agree to submit to an examination at your own expense if the Executive Director of the Board of Medical Licensure and Discipline deems it necessary to determine whether your physical and/or mental impairment presents a significant risk to the health or safety of patients or otherwise causes you not to be fully qualified to practice medicine in a competent and professional manner with safety to patients without limitations or accommodations? Yes No **If no, submit a signed, notarized statement fully explaining your answer.**

DUTY TO REPORT

35. 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

36. 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

37. 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 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

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.

If your application requires Board review, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

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

Applications that are not complete within six months of filing may be considered abandoned and discarded.

Please note: 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 hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine whether I have previously engaged in unprofessional conduct as defined in 24 Del. C. §1731 or the Rules and Regulations of the Delaware Board of Medical Licensure and Discipline and to determine that I am physically and mentally capable of engaging in the practice of medicine with safety to the public.

I authorize 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 Delaware Board of Medical Licensure and Discipline any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or other pertinent data and to permit the Delaware 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 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.



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SERVICE LETTER

Arrange for the Board office to receive this form directly from *each* healthcare facility where the Physician applicant currently has, or had within the past five years, either direct patient access or admitting or staff privileges.

<p>Release to be completed by Applicant</p>	<p>Healthcare Facility Name: _____</p> <p>Address: _____</p> <p>Applicant Last Name: _____ First: _____ Middle Initial: _____</p> <p>Other Name(s) Used: _____ Birth Date: _____</p> <p>I authorize a full release permitting the Delaware Board of Medical Licensure and Discipline to obtain any and all information pertaining to the facts of my current or previous relationship with this facility.</p> <p>Applicant Signature: _____ Date: _____</p>
<p>Questions to be answered by Responsible Physician</p> <p>Affix Hospital Seal</p> <p><small>If the hospital does not have a seal, a letter attesting to this fact, on hospital stationery, must accompany this form.</small></p>	<ol style="list-style-type: none"> 1. Was this applicant placed on probation, suspended or in any way sanctioned/disciplined while at your facility? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Was this applicant the subject of an investigation while at your facility? Yes <input type="checkbox"/> No <input type="checkbox"/> 3. Did this applicant leave your facility in good standing? Yes <input type="checkbox"/> No <input type="checkbox"/> 4. Would you recommend this applicant for privileges or consider rehiring this applicant at your facility? Yes <input type="checkbox"/> No <input type="checkbox"/> 5. What position did the applicant hold at your facility? _____ from ____/____/____ to ____/____/____ <p>If you answered "yes" to any of the above questions, please attach an explanation. You may also attach additional comments or information that the Board of Medical Licensure and Discipline should consider prior to determining this applicant's eligibility for licensure. All attachments should be on your facility's letterhead.</p> <div style="border: 1px solid black; padding: 5px;"> <p>A health care facility that fails to make a full and complete disclosure of information shall be subject to a civil penalty of \$10,000 for each such violation. Any health care facility providing information about an applicant as required by law shall be immune from claims, suits, liability, damages, or any other recourse, civil or criminal, so long as the person acted in good faith and without gross or wanton negligence. Good faith is presumed until proven otherwise, and gross or wanton negligence must be shown by the complainant. See 24 Del. C. §1730(b)(1)c and §1740(b).</p> </div> <p>I am licensed in the State of _____. I have known the applicant personally or professionally for the period ____/____/____ to ____/____/____.</p> <p>Name of Responsible Physician: _____ Title: _____</p> <p>Signature of Responsible Physician: _____ Date: _____</p> <p>Phone: _____ Fax: _____ Email: _____</p>

Mail (do not fax) completed, signed and sealed form directly to the Board office at the address above.



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VERIFICATION OF PHYSICIAN LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice medicine.

Licensing Authority: _____		Applicant Name: _____	
Address: _____		Home Address: _____	
City/State/Zip: _____		City/State/Zip: _____	
This section to be completed by Applicant	Last Name: _____ First: _____ Middle: _____		
	SSN: _____ DOB: _____		
	Other Name(s) Used: _____		
	License Number(s) in Jurisdiction Named Above: _____		
	<p>I am applying for licensure as a Physician in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Medical Licensure and Discipline. <u>This includes any medical training licenses.</u></p>		
Applicant Signature: _____		Date: _____	
This section to be completed by Licensing Authority	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of _____ License Number: _____		
	Issue Date (month/day/year): _____ Expiration Date (month/day/year): _____		
	Has any discipline activity taken place regarding this licensee? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please enclose a certified copy of the Board Order with this license verification.		
CERTIFICATION AFFIX OFFICIAL SEAL HERE	Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.		
	Printed Name of Official: _____		
	Signature of Official: _____		Date: _____
	Title: _____		
	Phone: _____ Fax: _____		Email: _____

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.



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VERIFICATION OF MEDICAL EDUCATION

Physician applicants who are *not* using the FCVS service should send this form to each medical school attended.

Educational Institution: _____ Address: _____ City/State/Zip: _____	Applicant Name: _____ Home Address: _____ City/State/Zip: _____															
This section to be completed by Applicant	Last Name: _____ First: _____ Middle: _____ SSN: _____ Birth Date: _____ Other Name(s) Used: _____ Applicant Signature: _____ Date: _____															
This section to be completed by Institution	1. Enter periods that the applicant named above was enrolled in institution: <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="padding: 5px;">YEAR</th> <th style="padding: 5px;">FROM (month/day/year)</th> <th style="padding: 5px;">TO (month/day/year)</th> </tr> </thead> <tbody> <tr><td style="padding: 5px;">1</td><td style="padding: 5px;"></td><td style="padding: 5px;"></td></tr> <tr><td style="padding: 5px;">2</td><td style="padding: 5px;"></td><td style="padding: 5px;"></td></tr> <tr><td style="padding: 5px;">3</td><td style="padding: 5px;"></td><td style="padding: 5px;"></td></tr> <tr><td style="padding: 5px;">4</td><td style="padding: 5px;"></td><td style="padding: 5px;"></td></tr> </tbody> </table> 2. Was the applicant awarded a degree? Yes <input type="checkbox"/> No <input type="checkbox"/> <ul style="list-style-type: none"> • If <u>yes</u>, enter: Degree Received: _____ Date Degree Conferred (month/day/year): _____ • If <u>no</u>, attach explanation of reason applicant did not receive a degree. 	YEAR	FROM (month/day/year)	TO (month/day/year)	1			2			3			4		
YEAR	FROM (month/day/year)	TO (month/day/year)														
1																
2																
3																
4																
AFFIX INSTITUTION OR NOTARY SEAL HERE	I certify that the information above is an accurate account of the applicant's records and is true and correct. Printed Name of Institution Official: _____ Signature of Official: _____ Date: _____ Title: _____ Phone: _____ Fax: _____ Email: _____															

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.



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

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

VERIFICATION OF POST-GRADUATE MEDICAL EDUCATION

Physician applicants who are *not* using the FCVS service should send this form to *each* program attended.

Educational Institution: _____	Affiliated University: _____				
Address: _____	Address: _____				
City/State/Zip: _____	City/State/Zip: _____				
This section to be completed by Applicant	Last Name: _____ First: _____ Middle: _____ SSN: _____ DOB: _____ Other Name(s) Used: _____				
Program Participation to be completed by Institution	<ul style="list-style-type: none"> Use one section per department. If department is rotating or traditional, provide a schedule of rotations. Report Internships, Residencies and Fellowships separately. If the PGY is currently underway, report the expected completion date in the TO field. Report incomplete PGY's separately from successfully completed PGY's. 				
	<table style="width:100%; border: none;"> <tr> <td style="width:30%; border: none;">PGY Year: _____</td> <td style="border: none;">Department: _____</td> </tr> <tr> <td style="border: none;"> <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other </td> <td style="border: none;"> From (month/day/year): _____ To (month/day/year): _____ Successfully completed? Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Accreditation: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> Not Accredited <input type="checkbox"/> Other <input type="checkbox"/> Explain: _____ </td> </tr> </table>	PGY Year: _____	Department: _____	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other	From (month/day/year): _____ To (month/day/year): _____ Successfully completed? Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Accreditation: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> Not Accredited <input type="checkbox"/> Other <input type="checkbox"/> Explain: _____
	PGY Year: _____	Department: _____			
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Questions to be completed by Institution	<ol style="list-style-type: none"> 1. Did this applicant ever take a leave of absence or break from training? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Was this applicant ever placed on probation? Yes <input type="checkbox"/> No <input type="checkbox"/> 3. Was this applicant ever disciplined or placed under investigation? Yes <input type="checkbox"/> No <input type="checkbox"/> 4. Did the instructors file any negative reports on this applicant? Yes <input type="checkbox"/> No <input type="checkbox"/> 5. Were any limitations or special restrictions placed on this applicant because of questions of academic incompetence, disciplinary problems or any other reasons? Yes <input type="checkbox"/> No <input type="checkbox"/> <p>Explain yes answers and any other unusual circumstances on a separate sheet.</p>				
CERTIFICATION	I certify that the information above is an accurate account of this individual's records and is true and correct.				
AFFIX INSTITUTION OR NOTARY SEAL HERE	Print Name of Program Director (MD or DO): _____ Signature of Program Director: _____ Date: _____ Phone: _____ Fax: _____ Email: _____				

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.

Instructions for Requesting a Criminal Background Check

Both state and federal criminal background checks are required.

Locations

Kent County – Primary Facility

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

Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 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

Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)

By appointment only

Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties 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 \$69.00, to cover both the State and Federal 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.

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.
2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, 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 \$69.00 made payable to "Delaware State Police" to:

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

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

DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE



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CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT OR TYPE ALL INFORMATION IN BLACK INK.

CHECK TYPE OF LICENSURE FOR WHICH APPLYING:

- | | | |
|--|--|---|
| <input type="checkbox"/> Adult Entertainment | <input type="checkbox"/> Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Acupuncture Practitioners, Genetic Counselors) | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Deadly Weapons Dealer | <input type="checkbox"/> Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT) | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Nursing (RN, LPN, APN) | <input type="checkbox"/> Social Work |
| | <input type="checkbox"/> Nursing Home Administrator | <input type="checkbox"/> Texas Hold'em Individual |

ENTER FULL CURRENT NAME:

_____	_____	_____	_____
Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)

ENTER ALL OTHER NAMES USED IN THE PAST (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

AUTHORIZATION TO RELEASE INFORMATION

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date:** _____

Phone: Home _____ Work: _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO: **Division of Professional Regulation**
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.



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PHYSICIAN SELF-REPORT FORM

The Physician's mandatory duty to self-report is in 24 Del C. § 1730 and § 1731A. To comply with your duty, complete and submit this form to the Board of Medical Licensure and Discipline within the required time limit. You may duplicate the form.

IDENTIFYING AND CONTACT INFORMATION

- 1. Physician Name: _____

Last
First
Middle
- 2. Delaware License No: C___ - _____
- 3. Mailing Address: _____

City
State
Zip
- 4. Office Phone: _____ Email: _____

MALPRACTICE COMPLAINT

- 5. Plaintiff Name: _____ Age: _____ Sex: _____
- 6. Address of Record: _____
- 7. Date of Occurrence: _____
- 8. Place of Occurrence (office, hospital name & address): _____
- 9. What was your position in case (e.g., resident, primary physician)? _____
- 10. Who was the complaint filed against? Individual Doctor Group Hospital
- 11. Names of other defendant-doctors and/or hospitals: _____

DISPOSITION

- 12. What was the disposition? Verdict Settled
- 13. Final Disposition: _____ Date: _____
- 14. Civil Case No.: _____ Attorney: _____
- 15. Total Amount Paid (if any): _____
- 16. Amount Attributable to You: _____
- 17. Insurance Company Covering You for this Incident: _____

Signature: _____ **Date:** _____

You may attach a detailed explanation of the medical issues involved in the referenced litigation.

