



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

APPLICATION FOR PHYSICIAN ASSISTANT LICENSE 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.

Physician Assistant Prescriptive Authority

This application includes a section to concurrently apply for Prescriptive Authority. Prescriptive Authority enables you to prescribe medication under the supervision of a licensed physician in Delaware.

- If you do not wish to apply concurrently for Prescriptive Authority, you may apply later. To apply later, use the [Physician Assistant Application for Prescriptive Authority](#).
- Prescriptive authority alone does **not** confer the right to prescribe controlled substances in Delaware. See the **Important Information about Prescribing Controlled Substances** section below.
- If you apply for your Physician Assistant license and CSR at the same time, the CSR application will be processed *after* your prescriptive authority is approved. When your Delaware CSR is approved, you must then file for a [federal DEA registration](#) for Delaware.

Requirements for All Applications

- Submit completed, signed and notarized [Application for Physician Assistant License](#).
 - 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.
- Submit an 8" X 11 1/2" copy of your Physician Assistant diploma.
- Arrange for the Board office to receive a *Verification of Physician's Assistant Education* form from the PA program from which you graduated.
 - The program from which you graduated must be AMA-approved.
 - The Board office must receive the completed form *directly* from the 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.
- Arrange for the Board office to receive an official *Verification of Certification* from [NCCPA](#), sent directly to the Board office.
- If you now hold, or have ever held, a PA license in any jurisdiction (state, U.S. territory or District of Columbia) other than Delaware, arrange for the Board office to receive a *Verification of Physician Assistant 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.

- 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.
- 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 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 Continuing Medical Education Requirement

The following requirement pertains only when

- you hold a *current* PA license in another jurisdiction **or** you are reapplying for Delaware PA licensure that lapsed
 - your CME within the past two years is current.
- Submit proof of 100 hours of continuing medical education (CME).
- The CME must consist of 40 hours of AMA Category I CME (Section 25.2 of the Board's [Rules and Regulations](#)).

Temporary Licensure

The temporary permit allows you to practice until you have passed the Physician Assistant National Certifying Examination (PANCE) and your permanent license is issued. You may be granted a temporary license if you

- have graduated from an accredited PA program and otherwise meet **all** the requirements for licensure except for passing the PANCE, **and**
- have registered to take the next available PANCE.

The temporary license remains valid until the examination results are available. If you fail the PANCE, the temporary license immediately becomes null and void and you must cease practicing as a PA.

To apply for a temporary permit...

- Answer "yes" to Question 2 on the application form.
- Enclose the [temporary license fee](#) by check or money order made payable to "State of Delaware."
 - This fee is *in addition to* the processing fee for your application. However, you may combine the fees in one check or money order.

Important Information about Controlled Substance Registrations

If you receive prescriptive authority, you may prescribe **only non-controlled substances**. To prescribe controlled substances in Delaware, you must have **all** of the following:

- Delaware PA license **with** prescriptive authority
- At least one supervising physician for *each* individual business/practice where you practice in Delaware
- Delaware CSR

Note: If you practice at more than one business/practice, you need only a single CSR to **prescribe** at all of the locations. However, every Delaware location where controlled substances are dispensed/stored must be covered by a CSR. If no other practitioner (e.g., physician), physician assistant or APN holds a Delaware CSR for a location where you will **store/dispense**, as well as prescribe, controlled substances, you must file for an additional CSR for the location.
- Federal DEA registration for Delaware (a DEA registration in another jurisdiction is not sufficient)

To apply for a CSR(s), see [Controlled Substances Application for Advanced Practice Nurses](#), available on dpr.delaware.gov. For Federal DEA registration, see [DEA New Registration Applications](#).



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APPLICATION FOR PHYSICIAN ASSISTANT LICENSE

TYPE OF APPLICATION

1. Select the item that describes your situation (check one):

- I have *never* held a PA license in *any* jurisdiction and am applying on the basis of the Physician Assistant National Certifying Examination (PANCE).
 I hold a *current, active* PA license in another jurisdiction.
 I am re-applying because my Delaware PA license has lapsed. My license number was: **C5** - _____

2. Are you also applying for a temporary license because you have not yet passed the PANCE? Yes No

3. Are you also applying for Prescriptive Authority? Yes No If yes, check one:

- Non-Controlled Substances *Only* *Both* Controlled and Non-Controlled Substances

The application for prescriptive authority is NOT an application for a controlled substance registration (CSR). To apply for a CSR, see [Application for Controlled Substances Registration – Physician’s Assistants](#).

IDENTIFYING AND CONTACT INFORMATION

4. Full Name: _____
Last First Middle

5. Other Names Used: _____

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 the SSN: _____
 If no, you must file a [Request for Exemption from Social Security Number Requirement](#).

8. Mailing Address: _____

_____ City State Zip

9. Phone: _____ Home Work Email: _____

EDUCATION, EXAMINATIONS AND CERTIFICATION – All applicants complete this section.

10. Are you a graduate of an AMA-approved PA program? Yes No If yes, enter this information:

Institution Name: _____ Graduation Date: _____

Address: _____
Street City State Zip

Submit an 8" X 11 1/2" copy of your Physician Assistant diploma and arrange for the Board office to receive a Verification of Physician’s Assistant Education form from the PA program, sent *directly* from the school(s).

11. Have you ever been deemed ineligible to sit for a PA national certifying examination for any reason? Yes No
If yes, explain: _____

12. Are you certified as a PA by the National Commission on Certification of Physician Assistants (NCCPA)?
Yes No If yes, enter the following information about your certification and *skip to the CME section*:

Certification Number: _____ Date of Certification: _____

Arrange for the Board office to receive an official Verification of Certification sent directly from NCCPA to the Board office.

13. Have you taken the national certifying examination? Yes No

- If yes, enter the date you sat for the exam: _____
- If no, enter the date of the exam for which you have registered: _____

CONTINUING MEDICAL EDUCATION – Complete this section *only if you hold a current PA license in another jurisdiction or you are reapplying for Delaware PA licensure that lapsed.*

14. Do you currently log continuing medical education (CME) with a nationally recognized agency? Yes No If yes, check agency:

- NCCPA
- AAPA
- Other – Enter agency: _____

15. Within the past two years, have you completed at least 100 hours of CME, 40 of which are Category I CME?
Yes No **If yes, submit proof of your current CME.**

LICENSURE HISTORY – All applicants complete this section.

16. Have you ever been denied a license or a registration to practice as a PA? Yes No If yes, explain:

17. Have you ever held a PA license in any jurisdiction (state, U.S. territory, District of Columbia) other than Delaware?
Yes No **If yes, list each jurisdiction where you now hold, or have ever held, a PA license and continue with the next question. If no, skip to the DISCLOSURES section.**

JURISDICTION	LICENSE NUMBER	EXPIRATION DATE

Arrange for the Board office to receive a Verification of Physician Assistant License form from each jurisdiction where you have held a license.

18. Have you been actively practicing as a licensed physician assistant? Yes No

DISCLOSURES – All applicants complete this section. **If a question in this section directs you to submit a signed statement to explain your answer, the statement should specify where and when the incident occurred, 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 **If yes, submit a signed statement explaining fully.**

Arrange for the Board office to receive state and federal criminal background checks.

20. Are any criminal charges against you pending in any jurisdiction? Yes No **If yes, submit a signed statement explaining fully.**

21. Have you ever been disciplined or had formal written action taken by a hospital staff or medical society, or licensing board of another jurisdiction? Yes No **If yes, submit a signed statement explaining fully.**

Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) and, when you receive the report, mail the original to the Board office.

22. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes No **If yes, submit a signed statement explaining fully and a copy of any documents in your possession related to the final disposition of the investigation. Continue with the next question. If no, skip to Question 24.**
23. 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
24. Within the past two years, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as a physician assistant, including use or abuse of dangerous or addicting substances? Yes No **If yes, submit a signed statement explaining fully. Continue with the next question. If no, skip to Question 26.**
25. 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
26. Within the past two years, have you engaged in the illegal use of controlled dangerous substances? Yes No **If yes, submit a signed statement explaining fully.**
27. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes No **If yes, submit a signed statement explaining fully.**

DUTY TO REPORT – All applicants complete this section.

28. 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

29. 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

30. 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

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.

PRESCRIPTIVE AUTHORITY – Complete this section *only if* you answered “Yes” to Question 3 (applying for prescriptive authority).

31. Enter the names of **all** physicians who will supervise you, regardless of business/practice or location:

Arrange for **each** supervising physician you listed above to submit a **Statement of Supervising Physician** (see next page). Enclose all statements with the application.

STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: _____
2. Delaware Physician License Number: **C** ___ - _____ 3. Specialty: _____
4. DEA Numbers : _____
Federal Delaware
5. Which controlled substance schedules are you authorized to prescribe? II III IV V
6. **Which controlled substance schedules is the Physician Assistant applicant authorized to prescribe under your supervision?** II III IV V
7. Are you delegating authority to the Physician Assistant applicant to request and issue professional samples of controlled legend medications? Yes No **If yes, as the supervising physician, you remain ultimately responsible for prescribing, dispensing and storing the controlled substances even though you are delegating authority to the PA.**
8. **As the supervising physician, I understand that I may not at any given time supervise more than two physician assistants, unless a regulation of the Board increases or decreases the number (24 Del C. §1771(e)).** Yes No
9. How many Physician Assistants do you currently supervise? _____
10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized. Yes No

Signature of Supervising Physician: _____ **Date:** _____

You may copy this page.

STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: _____
2. Delaware Physician License Number: **C** ___ - _____ 3. Specialty: _____
4. DEA Numbers : _____
Federal Delaware
5. Which controlled substance schedules are you authorized to prescribe? II III IV V
6. **Which controlled substance schedules is the Physician Assistant applicant authorized to prescribe under your supervision?** II III IV V
7. Are you delegating authority to the Physician Assistant applicant to request and issue professional samples of controlled legend medications? Yes No **If yes, as the supervising physician, you remain ultimately responsible for prescribing, dispensing and storing the controlled substances even though you are delegating authority to the PA.**
8. **As the supervising physician, I understand that I may not at any given time supervise more than two physician assistants, unless a regulation of the Board increases or decreases the number (24 Del C. §1771(e)).** Yes No
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Signature of Supervising Physician: _____ **Date:** _____

STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: _____
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8. **As the supervising physician, I understand that I may not at any given time supervise more than two physician assistants, unless a regulation of the Board increases or decreases the number (24 Del C. §1771(e)).** Yes No
9. How many Physician Assistants do you currently supervise? _____
10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized. Yes No

Signature of Supervising Physician: _____ **Date:** _____

32. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized. Yes No

To assure consideration of your license application at the next Board meeting, 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 permanent Physician Assistant 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 there under.

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.

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. Send 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:

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

ENTER FULL CURRENT NAME:

Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)
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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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VERIFICATION OF PHYSICIAN ASSISTANT LICENSE

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

Licensing Authority: _____		Applicant Name: _____	
Address: _____		Home Address: _____	
City/State/Zip: _____		City/State/Zip: _____	
This section is to be completed by applicant.	Last Name: _____ First: _____ Middle: _____		
	SSN: _____ DOB: _____		
	Other Name(s) Used: _____		
	License Number(s) in Jurisdiction Named Above: _____		
I am applying for licensure as a Physician Assistant 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.			
Applicant Signature: _____ Date: _____			
This section to be completed by Licensing Authority.	Our records indicate that the applicant named above was licensed in the State/U.S. Territory 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 PHYSICIAN ASSISTANT EDUCATION

Physician Assistant applicants should send this form to the program from which graduated.

Educational Institution: _____		Applicant Name: _____	
Address: _____		Home Address: _____	
City/State/Zip: _____		City/State/Zip: _____	
This section is to be completed by applicant.	Last Name: _____ First: _____ Middle: _____		
	SSN: _____ Birth Date: _____		
	Other Name(s) Used: _____		
<p>I am applying for licensure as a Physician Assistant in the State of Delaware. Before my application can be reviewed, verification of my degree or certification is required. I am authorizing the release of the information requested on this form.</p>			
Applicant Signature: _____ Date: _____			
This section to be completed by Institution.	1. Enter the dates the applicant named above was enrolled in your institution: From (month/day/year): _____ To (month/day/year): _____		
	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. 		
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.



DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM



Instructions: Follow these instructions to submit this form to the Department of Services for Children, Youth and Their Families (DSCYF). Do NOT send this form to the Division of Professional Regulation.

- Type or clearly print all information
Do not use a cover sheet.
Do not send duplicate requests.
Submit form to DSCYF within 90 days of signature date.
Allow 15 working days for results to be processed.

Fax or Mail Request to: DSCYF, OCCL
Criminal History Unit
1825 Faulkland Road
Wilmington, DE 19805
Fax: 302-633-5191

DSCYF Phone: For questions about the Child Protection Registry, call DSCYF at (302) 892-5800 Please note that DSCYF cannot answer questions about your professional licensure application. For questions about professional licensure, contact the Division of Professional Regulation at (302) 744-4500.

PART I. APPLICANT INFORMATION

Name: Last First Middle

Other Name(s) Used:

Delaware Drivers License #: Social Security Number:

Date of Birth: mm / dd / yyyy Sex: Male Female: Race:

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

Check only one: Education Healthcare Facility Child Care Other: State Agency

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: Sherianne Eley

DSCYF USE ONLY:
The individual listed above (is listed) (is NOT listed) on the Delaware Child Protection Registry.
Date: DSCYF Criminal History Unit: