



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

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF PODIATRY

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

**PODIATRIC PHYSICIAN IN-TRAINING APPLICATION
INSTRUCTION SHEET**

General Information

File this application if you are a Podiatric Physician participating in an:

- In-state Delaware residency program, **or**
- Out-of-state residency program that has a rotation of 45 days or longer in Delaware.

As a Podiatrist In-Training licensee, you are limited to the practice of medicine within the hospital where you are employed except for any outside medical duties that may be assigned as part of the residency program. The outside duties must be performed under the supervision of a fully licensed podiatric physician.

Requirements for All Applicants

- Submit completed, signed and notarized [Application for Podiatric Physician In-Training Application](#).
- Enclose [processing fee](#) by check or money order made payable to "State of Delaware."
- Arrange for the Board office to receive an official transcript sent *directly* from your school of podiatric medicine to Board office.
 - If you have not graduated at the time of application, arrange for the Board office to receive a letter from the school. The letter must attest that you are in good academic standing and state your expected completion date and degree.
- Arrange for the Board office to receive score reports sent directly from the following exam services:
 - For scores on the American Podiatric Medical Licensing Examinations (APMLE) Parts I and II, see www.nbpme.org.
 - For scores on the APMLE Part III, see www.fpmb.org.
- Arrange for the Board office to receive verification of licensure from *each* jurisdiction (state, U.S. territory or District of Columbia) in which you hold, or have *ever* held, a license to practice podiatric medicine, sent *directly* from the state 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.
- Arrange for your Resident Program Director and Supervising Physician to complete and sign the *Residency Program Director's Affidavit* included with application.

Reporting Requirement

You must notify the Board office within three days after you complete or withdraw from the residency program.



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PODIATRIC PHYSICIAN IN-TRAINING APPLICATION

IDENTIFYING AND CONTACT INFORMATION

1. Name: _____
Last/Family First Middle
2. Other Names Used: _____
3. Date of Birth (month/day/year): _____ Gender: Male Female
4. 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](#).
5. Address: _____
Street

City State Zip Code
6. Day Phone: _____ Email: _____

EDUCATION AND EXAMINATIONS

7. Enter the following information about your medical school:
- Name: _____ Department: _____
- Graduation Date: _____ Check one: Actual Date or Expected Date
- Address: _____
- If you have graduated, arrange for your school to send an official transcript *directly* to the Board office. If you have not yet graduated, arrange for the school to send a letter directly to the Board office. The letter must attest that you are in good academic standing and state your expected completion date and degree.**
8. Enter the following information about your residency:
- Training Institution: _____ Department: _____
- Address: _____
Street

City State Zip Code
- Phone: _____ Date Training Expected to Begin: _____

9. Are you, or have you been, affiliated with any hospitals? Yes No If yes, list your hospital affiliations. If you need more room, attach a separate list with the same information.

HOSPITAL	ADDRESS	SERVICE DATES

10. Have you taken and passed the American Podiatric Medical Licensing Examinations Parts I, II, and III? Yes No If yes, enter the requested information about your exams:

Request the exam service to send score reports *directly* to the Board office.

EXAMINATION	SCORE	EXAM DATE
APMLE Part I		
APMLE Part II		
APMLE Part III		

LICENSURE AND PRACTICE HISTORY

11. Have you ever been granted a podiatric or other healthcare license by any jurisdiction (U.S. state, territory or District of Columbia)? Yes No If yes, complete the following for all licenses. Use a separate sheet if necessary.

LICENSE TYPE	LICENSE NUMBER	ISSUING JURISDICTION	EFFECTIVE DATES

Arrange for the Board office to receive a license verification from *each* jurisdiction listed above, sent *directly* from the state to the Board office.

DISCLOSURES

12. 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 certified copy of your criminal history record.
13. Have you ever been *denied* a podiatric or other healthcare license by any jurisdiction? Yes No If yes, explain fully on a separate sheet of paper. Include the license type, jurisdiction, and the reason for each denial.
14. Have you been the recipient of any administrative penalties regarding your practice of podiatry in any jurisdictions – such as fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations – or have you been a party to a consent agreement containing conditions placed by a board on your professional conduct and practice, including any voluntary surrender of a license? Yes No If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
15. Have you ever had a podiatric license revoked, suspended, limited, or placed on probation? Yes No If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
16. Have you ever had a disciplinary action taken against you by a Podiatric Medical Society? Yes No If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
17. Has a hospital ever changed your privileges as a result of a disciplinary action? Yes No If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.

18. Are any unresolved complaints pending against you? Yes No If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
19. Are any charges pending against you, or are you currently under investigation for felony, misdemeanor, unprofessional conduct, professional misconduct, or malpractice? Yes No If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
20. Have you ever been denied a narcotic license (controlled substance registration) or had such license modified, restricted, suspended, canceled, or revoked, or have you ever prescribed narcotic drugs unlawfully? Yes No If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
21. Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department, the Drug Enforcement Agency of the Department of Justice, or any state's Narcotic Agency in this country or any other country? Yes No If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
22. Have you ever:
- Engaged in the practice of podiatric medicine without a license? Yes No
 - Employed or knowingly cooperated in fraud or material deception to acquire a podiatric license? Yes No
 - Impersonated another person holding a podiatric license? Yes No
 - Allowed another person to use your podiatric license? Yes No
 - Aided or abetted anyone not licensed as a podiatrist to represent him or herself as a podiatrist? Yes No
- If yes to any one of the above, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
23. Have you ever entered into a settlement, or had a verdict rendered against you, in a malpractice action? Yes No If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
24. Are you now, or within the last three years have you been, dependent upon the use of alcohol, stimulants, or habit-forming drugs or alcohol or been treated or disciplined for their use? Yes No If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.
25. Have you had either a mental or physical illness which interfered with your practice for over a month? Yes No If yes, explain fully on a separate sheet of paper.
26. Are you currently physically and mentally *capable* of practicing podiatric medicine and surgery according to generally accepted standards? Yes No If no, continue with the next question. If yes, skip to the DUTY TO REPORT section.
27. Do you agree to submit to an examination to determine such capability as the Board may deem necessary? Yes No

DUTY TO REPORT

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** duty to **self report** when your podiatrist license in another jurisdiction has been subject to discipline or has been surrendered, suspended or revoked.

I certify that I have read and understand [24 Del. C. §515 \(a\)\(9\)](#) and that I understand my *duty to self report*.
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. If your application is approved by the Board, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I certify that I meet all the requirements for licensure specified in 24 Del. C. §508(a)(1) through (a)(7), except for completion of the residency program required by §508(a)(2). *I further certify that I intend to limit myself solely to practice within the hospital of my residency or the performance of such medical duties outside the hospital that may be assigned to me as part of the residency program.*

APPLICANT SIGNATURE: _____ Date: _____

State of _____, County of _____

Sworn and subscribed before me this _____ day of _____ 2_____.

Notary Public Signature: _____

SEAL

My Commission Expires: _____

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



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RESIDENCY PROGRAM DIRECTOR'S AFFIDAVIT

Name of Applicant for Podiatric In-Training License: _____

RESIDENCY PROGRAM DIRECTOR

The residency program director for the applicant's training institution completes this section in the presence of a notary public.

Printed Name of Residency Program Director: _____

Program Director's Delaware License No: _____

- I verify that the above-named applicant will be participating in a training program at:

Name of Institution: _____ Start Date (month/day/year): _____

- I verify that the applicant will be participating in this training program under the supervision of a fully licensed podiatric physician in the State of Delaware.
- I further verify that the applicant's credentials have been reviewed and approved.

Signature of Residency Program Director: _____ Date: _____

State of _____, County of _____

Sworn and subscribed before me this _____ day of _____ 2 _____

Signature of Notary Public: _____

SEAL

My Commission Expires: _____

SUPERVISING PHYSICIAN

The applicant's supervising physician completes this section.

Printed Name of Supervising Physician: _____

Delaware License No: _____

I accept responsibility for the practice of medicine and surgery of this applicant in this institution.

Signature of Supervising Physician: _____ Date: _____