



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

APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE INSTRUCTION SHEET

Selecting Type of Application

The application asks you to select the type of application you are filing. The two types of application are *Direct Application* and *Reciprocity*. Which you choose depends on whether you are *currently* licensed in another jurisdiction (state, U.S. territory or District of Columbia) and, if so, whether any of the jurisdictions has licensure requirements substantially similar to those of Delaware.

Select **Direct Application** if *either* of these situations applies to you:

- You recently completed your residency year and are **not** licensed in another jurisdiction, **or**
- You hold a current license in another jurisdiction(s) but you have **not** practiced podiatric medicine *at least* five years **and none** of the jurisdictions where you are currently licensed has licensure requirements that are substantially similar to those of Delaware.

Select **Reciprocity** if you are *currently* licensed in another jurisdiction **and either** of these situations applies to you:

- A jurisdiction where you are currently licensed has licensure requirements that are substantially similar to those of Delaware, **or**
- You have practiced podiatric medicine *at least* five years in a jurisdiction where you are currently licensed even though the jurisdiction does not have licensure requirements substantially similar to Delaware's.

To compare the licensure requirements of a jurisdiction where you are currently licensed to those of Delaware, see Section 4.2 of the Board's [Rules and Regulations](#).

If you select Reciprocity, the Board will compare the licensure requirements of each jurisdiction where you hold a current license to those of Delaware. If the Board determines that **none** of the jurisdictions has substantially similar requirements **and** you have **not** practiced podiatric medicine for five years, you would be required to meet the requirements for licensure by Direct Application because you cannot be licensed by Reciprocity.

Requirements for All Applicants

These requirements apply regardless of whether you apply by Direct Application or Reciprocity.

- Submit a completed, signed, notarized [Application for Licensure to Practice Podiatric Medicine](#).
- 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.
- 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.
- Arrange for the Board office to receive verification of licensure from *each* jurisdiction in which you hold, or have ever held, a license to practice podiatric medicine, sent *directly* from the jurisdiction to the Board office.
 - If applying by Reciprocity, you must hold a *current* license in at least one of these jurisdictions.

- 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 Requirements for *Direct Applicants*

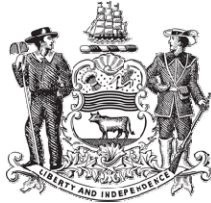
The following requirements apply only if you select Direct Application:

- Submit a certificate or equivalent proof that you have completed your residency.
- 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.

Additional Requirements for *Reciprocity Applicants*

The following requirements apply only if you select Reciprocity. To be licensed by Reciprocity without five years of practice, at least one jurisdiction where you are currently licensed must have licensure requirements substantially similar to Delaware's. However, if you have practiced podiatric medicine for at least five years, it is not necessary for a jurisdiction where you are currently licensed to have licensure requirements substantially similar to Delaware's.

- Provide copies of the current Podiatry laws and rules/regulations from each jurisdiction where you are currently licensed.
- If you have practiced podiatric medicine for at least five years, submit proof of five years of practice.
- For periods of employment, arrange for your employers to submit [Verification of Employment](#) forms directly to the Board office.
 - For periods of self-employment, submit copies of tax forms or business licenses.



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APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE

TYPE OF APPLICATION

1. Select the type of application you are filing (check one). The Instruction Sheet explains these types.

- Direct Licensure
 Reciprocity – I hold a *current* license in these jurisdictions: _____

If you are applying by *Reciprocity*, submit current copies of Podiatry statutes and rules and regulations from each jurisdiction listed above.

IDENTIFYING AND CONTACT INFORMATION

2. Name: _____
Last/Family First Middle

3. Other Names Used: _____

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

5. 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](#).

6. Address: _____
Street

City State Zip Code

7. Day Phone: _____ Email: _____

EDUCATION AND EXAMINATIONS

8. Enter the following information about the institution where you received your DPM:

Name: _____ Date of Degree: _____

Address: _____

Arrange for your school to send an official transcript *directly* to the Board office.

9. Enter the following information about your residency:

Hospital Name: _____

Address: _____

Director: _____ Attendance Dates: _____
From To

If applying by *Direct Application*, submit a certificate or other proof of completing your residency.

10. Enter the requested information about your exams:

If applying by *Direct Application*, arrange for the Board office to receive score reports sent *directly* from the exam service.

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 license by any jurisdiction (state, U.S. territory or D.C.)? Yes No If yes, complete the following for all licenses. Use a separate sheet if necessary.

JURISDICTION	LICENSE NUMBER	ISSUE DATE	STATUS (current or expired)

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

12. Have you ever held any other healthcare license? Yes No If yes, enter the following information about *each* license:

TYPE OF LICENSE	JURISDICTION	HAS THIS LICENSE BEEN DISCIPLINED?	IF DISCIPLINED, EXPLAIN:
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	

13. Enter the following information about the locations and dates of your practice. *Include military service.*

EMPLOYER/ PRACTICE NAME	ADDRESS WHERE PRACTICED	NATURE OF PRACTICE	EMPLOYMENT DATES

If you are applying by *Reciprocity* and no jurisdiction where you are currently licensed has substantially similar requirements to those of Delaware, you must document at least five years of practice after licensure. For periods of employment, arrange for your employer(s) to send *Verification of Employment* forms directly to the Board office. For periods of self-employment, submit tax forms or business licenses for the periods.

14. List hospital staff affiliations and duration. Attach additional sheets if needed.

HOSPITAL NAME	COMPLETE ADDRESS	SERVICE DATES

DISCLOSURES

15. 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, including any offense for which you have received a pardon, in any jurisdiction? Yes No If yes, submit a certified copy of your criminal history record.
16. 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.
17. 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.
18. 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.
19. 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.
20. 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.
21. 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.
22. 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.
23. 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.
24. 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.
25. 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.

26. 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.
27. 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.
28. 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.
29. 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.
30. Do you agree to submit to an examination to determine such capability as the Board may deem necessary?
Yes No

DUTY TO REPORT

31. 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

32. 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

33. 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.

Please note: When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

This section to be completed in the presence of a notary public.

SIGNATURE: _____ Date: _____

State of _____ County of _____

The above applicant, being sworn, deposes and says that he or she is attesting that all statements contained in his or her application are true and correct in every respect, and that he or she has not suppressed any information that might affect this application.

Sworn to me before me this _____ day of _____, 2_____

Signature of Notary Public: _____

SEAL

My commission expires on _____

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



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EMPLOYMENT VERIFICATION FORM

Applicants for Delaware podiatric licensure by Reciprocity must arrange for the Board to receive documentation of five years of practice after licensure if the jurisdiction where they are licensed does not have licensure requirements that are substantially similar to those of Delaware (Section 4.4 of the Board's Rules and Regulations). The purpose of this form is to document periods of podiatric employment in such jurisdictions.

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

Complete and sign this release. Send a copy to each employer.

Applicant Name: _____ Social Security Number: _____

I authorize release of information about my podiatric employment to the Delaware Board of Podiatry.

APPLICANT SIGNATURE: _____ Date: _____

EMPLOYMENT INFORMATION

Complete and sign in the presence of notary. Only forms mailed directly from the employer will be accepted. Forms returned by the applicant will not be accepted. Faxed forms will not be accepted.

1. Name of Practice Where Applicant Employed: _____

2. Mailing Address: _____

3. Phone: _____ Email: _____

4. Name of Person Providing Verification: _____

5. Title: _____

6. The employee named above worked at this practice from _____ to _____
Start Date End Date

7. This employment was in the State of _____.

SIGNATURE OF EMPLOYER REPRESENTATIVE: _____ Date: _____

State of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, in the year _____

Notary Signature: _____ Commission expires: _____

SEAL

Mail completed, signed, notarized form directly to the Board of Podiatry at address above.