



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

STATE OF DELAWARE

BOARD OF CLINICAL SOCIAL WORK EXAMINERS

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

APPLICATION FOR LICENSURE AS A CLINICAL SOCIAL WORKER INSTRUCTION SHEET

Selecting Type of Application

Apply by *examination* if you:

- are requesting approval to take the national Association of Social Work Boards (ASWB) licensing examination, **or**
- have already passed the ASWB licensing examination *but* you do **not** hold a **current, clinical** social work license in another jurisdiction (state, U.S. territory or District of Columbia).

Apply by *reciprocity* if you:

- have already passed the national ASWB licensing examination, **and**
- hold a **current, clinical** social work license in another jurisdiction (state, U.S. territory or District of Columbia).

Requirements for All Applicants

- Submit completed, signed and notarized [application](#) form.
 - The application must clearly show the number of your **post-MSW degree clinical social work** hours.
 - Your clinical experience must consist of at least 3200 hours.
- Enclose the non-refundable [processing fee](#) by check or money order payable to the "State of Delaware."
- Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the 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.
- Arrange for your supervisor to complete and sign the *Supervisory Reference Form* included with the application. Your supervisor must send it *directly* to the Board office.
 - The form must document at least 1,600 hours under professional supervision acceptable to the Board.
 - The supervisor(s) must be a licensed clinical social worker (LCSW), master's level degree social worker (MSW), licensed psychologist, or a licensed psychiatrist.
- If no LCSW is (or was) available to supervise you, complete and submit a *Documentation of Attempts to Secure LCSW Supervision* form, included with the application (Section 4.1.1 of the Board's [Rules and Regulations](#)).
- If you have ever held a social work license in another jurisdiction (state, U.S. territory or D.C.), arrange for the Board office to receive verification of licensure from *each* jurisdiction where you have held a license, sent *directly* from the jurisdiction to the Board office.
- Arrange for your college or university to send an official transcript of your completed Masters degree *directly* to the Board office.
 - The college or university must be accredited by the Council on Social Work Education (www.cswe.org).
- If you have already passed the ASWB exam, arrange for the Board office to receive a certified score report, sent directly from ASWB to the Board office. To request the score report, see [Score Transfer](#) on the ASWB web site.

- If you have *not* passed the ASWB examination, the Board office will notify you when you are approved to take the exam. To register online with ASWB, see [ASWB Registration Information](#).
- For information about the examination, the [Candidate Handbook](#) is available on the ASWB web site. The Board office does not provide Candidate Handbooks.
 - When you are approved to sit for the examination, you have two years from the date of your application to pass. If you have not yet passed when the two years elapse, you must re-apply.
 - When the Board office receives the passing exam scores from ASWB, your license will be issued.

- 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.



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APPLICATION FOR LICENSURE AS A CLINICAL SOCIAL WORKER

TYPE OF APPLICATION

1. Select the type of application you are filing:

- Examination (check one):
- I am requesting approval to take the ASWB clinical examination.
 - I have passed the ASWB clinical examination *but* I do **not** hold a current **clinical license** in another jurisdiction. (Check this one if you don't hold any current license **or** if you hold a license but it is not a **clinical** license.)
- Reciprocity – I hold a **current, clinical license** in the jurisdiction of _____.

IDENTIFYING AND CONTACT INFORMATION

2. Name (no titles, credentials, etc.): _____
Last/Family First Middle
3. Other Name(s) 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. Mailing Address: _____
Street

City State Zip
7. Phone: _____ Home Work Email: _____

EDUCATION & EXAMINATION

8. Enter the following information about your graduate education.

DEGREE	DATE AWARDED	NAME OF INSTITUTION GRANTING DEGREE

Arrange for your college or university to send an official transcript of your completed Masters degree *directly* to the Board office.

9. Have you passed the ASWB clinical examination? Yes No **If yes, request ASWB to send a certified statement of your passing score on the examination to the Board office.**

LICENSURE HISTORY & PROFESSIONAL EXPERIENCE

10. Have you ever held a license in any other jurisdiction (state, U.S. territory or District of Columbia)? Yes No
 If yes, enter the following about *each* license:

JURISDICTION	LICENSE NUMBER	ISSUE DATE	STATUS (e.g., active)

Arrange for the Board office to receive verification of licensure *directly* from *each* jurisdiction where you have ever been licensed.

11. List your professional clinical social work experience ***after your Master's degree was conferred***.
- Start with your most recent experience and work backward.
 - "From" dates must ***not*** precede the date your degree was conferred. "To" dates must be *actual* dates – do ***not*** enter "present" or "current."
 - Enter the total number of hours worked, ***not the number of hours worked per week***.
 - If you need more room, enclose additional sheets with same information. ***Do not submit resumes.***

From: _____ To: _____ Total Number of Hours Worked: _____
 Employer: _____
 Address: _____
 Supervisor's Name: _____
 Supervisor Title/Professional Status: _____ Phone: _____
 Your Position/Title: _____
 Job Responsibilities and Activities (continue on separate sheet, if needed): _____

From: _____ To: _____ Total Number of Hours Worked: _____
 Employer: _____
 Address: _____
 Supervisor's Name: _____
 Supervisor Title/Professional Status: _____ Phone: _____
 Your Position/Title: _____
 Job Responsibilities and Activities (continue on separate sheet, if needed): _____

From: _____ To: _____ Total Number of Hours Worked: _____
 Employer: _____
 Address: _____
 Supervisor's Name: _____
 Supervisor Title/Professional Status: _____ Phone: _____
 Your Position/Title: _____
 Job Responsibilities and Activities (continue on separate sheet, if needed): _____

12. List present or former clinical supervisors who can verify your required post-Master's degree experience. **If no LCSW is (or was) available to supervise you, complete and submit a *Documentation of Attempts to Secure LCSW Supervision* form, included with the application.**

NAME	ADDRESS	PHONE	LICENSE #

Arrange for each supervisor listed to complete and sign the *Supervisory Reference Form* included with the application. Your supervisors must send the form *directly* to the Board.

DISCLOSURES

13. 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

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

14. Are criminal charges pending against you in any jurisdiction? Yes No **If yes, enclose a detailed explanation giving all particulars. Also, enclose any relevant documents.**
15. Has your license ever been revoked or suspended or has any other disciplinary action been taken by the authorities of another jurisdiction (including any state, D.C., U.S. territory or other country)? Yes No **If yes, enclose a detailed explanation giving all particulars. Include any relevant documents.**
16. Have you ever been denied licensure in any other jurisdiction? Yes No **If yes, enclose a detailed explanation giving all particulars.**
17. Is a complaint or disciplinary action pending against your license in any other jurisdiction? Yes No **If yes, enclose a detailed explanation giving all particulars.**
18. Are you presently in violation of any [Rule and Regulation](#) of the Delaware Board of Clinical Social Work Examiners? Yes No **If yes, enclose a detailed explanation giving all particulars.**
19. Are you in violation of any grounds for disciplinary actions listed in [24 Del. C., 3915](#)? Yes No **If yes, enclose a detailed explanation giving all particulars.**
20. Are you now, or have you ever been, dependent on the use of alcohol, stimulants, or habit-forming drugs? Yes No **If yes, enclose a statement explaining fully. Include any relevant documents.**
21. Have you ever been found mental incompetent by a physician? Yes No **If yes, enclose a statement explaining fully. Include any relevant documents.**

DUTY TO REPORT

22. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** duty to report, in writing, within 30 days of becoming aware of information that you reasonably believe indicates that **any healthcare provider** including (but not limited to) any practitioner certified and registered to practice medicine in Delaware or licensed by the Board of Clinical Social Work Examiners
- has engaged, or is engaging, in conduct that would constitute grounds of discipline under their licensing laws, or
 - may be unable to practice with reasonable skill and safety to the public by reason of mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol).

I certify that I have read and understand [24 Del. C. §3919](#), [24 Del. C. §1730](#), [24 Del. C. §1731](#) and [24 Del. C. §1731A](#) and that I understand my *duty to report* to the Division of Professional Regulation. Yes No

23. 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

24. You have a **mandatory** duty to report your knowledge of a colleague's impairment, incompetence or unethical conduct to the Board of Clinical Social Work Examiners when the colleague has not addressed the problem or when a client's welfare appears to be in danger.

I certify that I have read and understand Section 9.3.5 of the [Rules and Regulations](#) and understand my *duty to report*. Yes No

To ensure 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 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I certify that the information provided in this application is accurate and complete to the best of my knowledge and belief. I understand that the Delaware Board of Clinical Social Work Examiners has the right to deny or revoke licensure, if my application contains fraudulent information.

Signature of Applicant: _____ **Date:** _____

City of _____ County of _____

Before me personally appeared, _____, applicant, of lawful age, to me known to be the identical person who signed this document of application and being by me first duly sworn, on oath state that all the foregoing statements are true and correct to the best of his or her knowledge and belief.

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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SUPERVISORY REFERENCE FORM

INSTRUCTIONS

This form is to be completed by the supervisor of the person applying for a Delaware Clinical Social Worker license. The form's purpose is to document that the applicant has acquired two years of post-MSW degree clinical social work experience consisting of at least 3,200 hours, of which at least 1,600 hours were under the supervision of a licensed clinical social worker (LCSW), master's level degree social worker (MSW), licensed psychologist, or a licensed psychiatrist (24 Del. C. § 3907). During the period supervised, *at least one hour per week must be one-on-one face-to-face supervision* (Section 4.3 of the Board's Rules and Regulations). Additional forms are available on www.delaware.gov.

1. Applicant Name: _____

2. Supervisor Name: _____

3. Enter this information about your agency (if applicable):

Agency Name	
Address	
Phone	

4. Enter this information about your education at the time you supervised the applicant:

University	
Field	
Degree and Date Conferred	

5. Enter this information about your license during the period you supervised this applicant:

Type of License	
License Number	
Issue Date	

6. **Total Clinical Supervised Hours:** _____ 7. **Total Hours of One-To-One Supervision:** _____

8. Dates of Post Master's Supervised Clinical Social Work Experience: From: _____ To: _____
Month/Year Month/Year

9. Use of professional values and ethics, professional knowledge, professional identity and use of self and disciplined approach to the practice environment should be reflected in each of the practice skills listed below.

I attest that the applicant satisfactorily demonstrated the following practice skills during the 1600 hours of post-MSW degree professionally supervised clinical social work experience.	Answer each item:
Provides adequate clinical diagnoses and biopsychosocial assessments	Yes <input type="checkbox"/> No <input type="checkbox"/>
Performs short-term and/or long-term interventions	Yes <input type="checkbox"/> No <input type="checkbox"/>
Establishes treatment plans with measurable goals	Yes <input type="checkbox"/> No <input type="checkbox"/>
Adapts interventions to maximize client responsiveness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Recognizes when personal issues affect clinical objectivity	Yes <input type="checkbox"/> No <input type="checkbox"/>
Recognizes and operates within own practice limitations	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seeks consultation when needed	Yes <input type="checkbox"/> No <input type="checkbox"/>
Refers to sources of help when appropriate	Yes <input type="checkbox"/> No <input type="checkbox"/>
Practices within established ethical and legal parameters	Yes <input type="checkbox"/> No <input type="checkbox"/>

I attest that the applicant named above worked under my clinical supervision. I certify that I personally completed all sections of this form and the information provided herein is accurate and complete to the best of my knowledge and belief.

Signature of Supervisor: _____ **Date:** _____

Mail completed form directly to the Board office at the address above.



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DOCUMENTATION OF ATTEMPTS TO SECURE LCSW SUPERVISION

INSTRUCTIONS

The purpose of this form is to document your efforts to locate a Licensed Clinical Social Worker (LCSW) to supervise your post-masters experience. Complete it when:

- You have been unable to secure an LCSW as a supervisor, **or**
- You have completed post-masters experience under a supervisor who is not an LCSW.

The Board will consider this information when evaluating your application for licensure as a Clinical Social Worker (Section 4.1.1 of the Board's [Rules and Regulations](#)).

1. Applicant Name: _____
2. Have you contacted the office of the Board of Clinical Social Work Examiners to discuss possible supervisory contacts? Yes No If yes, enter the following information:
Date of Contact: _____ With whom did you speak? _____
3. Have you contacted the Delaware State University Department of Social Work? Yes No If yes, enter the following information:
Date of Contact: _____ With whom did you speak? _____
4. Have you searched for Licensed Clinical Social Workers in Delaware on the Division's website at dpr.delaware.gov (click on *Verify License Online*)? Yes No If yes, enter the following information:
Date Information Accessed: _____ Result: _____
5. Have you contacted any local social service agencies? Yes No If yes, enter the following information about each agency you contacted. If you need more room, enclose a separate sheet.

AGENCY NAME	CONTACT DATE	PERSON SPOKEN WITH

6. Have you contacted the Delaware Chapter of the National Association of Social Workers at www.naswde.org? Yes No If yes, enter the following information:
Date of Contact: _____ With whom did you speak? _____
7. Have you contacted the Association of Social Work Boards at www.aswb.org? Yes No If yes, enter the following information:
Date of Contact: _____ With whom did you speak? _____

8. Have you reviewed the telephone directory to identify all listings for Licensed Clinical Social Workers or Therapists? Yes No If yes, enter the following information about each listing you contacted. If you need more room, enclose a separate sheet.

DIRECTORY LISTING	CONTACT DATE	PERSON SPOKEN WITH

9. Enter the following information about all additional attempts and/or contacts, not covered in the questions above, that you have made to secure post-masters supervision from a LCSW:

PERSON SPOKEN WITH	CONTACT DATE	RESULT

10. Explain in detail the additional steps you took to secure a LCSW for supervision and why you were unable to locate a supervisory LCSW.

AFFIDAVIT

I certify that the information provided in this statement is accurate and complete to the best of my knowledge and belief. I understand that the Delaware Board of Clinical Social Work Examiners has the right to deny or revoke licensure, if I provide fraudulent information.

Signature of Applicant: _____ Date: _____

City of _____ County of _____

Before me personally appeared, _____, applicant, of lawful age, to me known to be the identical person who signed this document and being by me first duly sworn, on oath state that all the foregoing statements are true and correct to the best of his or her knowledge and belief.

Sworn to before me and subscribed in my presence this _____ day of _____, 2____.

Signature of Notary: _____

SEAL

My commission expires: _____



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VERIFICATION OF LICENSURE FORM

Section I – To be completed by applicant. Send form to jurisdictions where you are currently, or have ever been, licensed. You may copy this form.

Name: _____

License Type: _____ License Number: _____

Phone: _____ Email: _____

I hereby authorize _____ to release information regarding my licensure,
Name of state licensing Board/Authority
certification, or registration to the Delaware Board of Clinical Social Work Examiners.

Applicant Signature: _____ **Date:** _____

Section II - To be completed by State Licensure Board/Authority. Mail completed form *directly* to the Delaware Board at address above.

Date of Original Registration/Licensure: _____

Registration/License No: _____ Expiration Date: _____

Type of Examination: ASWB Clinical Other Specify: _____

Pass/Fail Status as Determined by ASWB: _____ Date of Examination: _____

Has the licensee ever been subject to any disciplinary action, or had his/her license suspended or revoked?
Yes No **If yes, enclose a certified copy of the board's final order.**

Are there current or pending disciplinary proceedings or unresolved complaints against the applicant? Yes No

I certify the statements contained herein are true and correct.

Name of Official: _____ Title: _____

Name of Licensure Authority: _____

Address: _____
_____ Phone: _____

AFFIX BOARD SEAL

Signature of Official: _____ **Date:** _____

Mail completed form directly to the Board office at the address above.

Instructions for Requesting a Criminal Background Check

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

Applicant Notification

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

Locations

Kent County – Primary Facility

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

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

New Castle County - Satellite Facility

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

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

Sussex County – Satellite Facility

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

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

Applicants in Delaware

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

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

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

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

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

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



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AUTHORIZATION FOR RELEASE OF INFORMATION
CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- | | | |
|--|--|--|
| <input type="checkbox"/> Adult Entertainment | <input type="checkbox"/> Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT) | <input type="checkbox"/> Physical Therapy/Athletic Trainer |
| <input type="checkbox"/> Charitable Gaming Vendor | <input type="checkbox"/> Nursing (RN, LPN, APRN) | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Nursing Home Administrator | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Real Estate Appraiser (includes Appraisal Management Company) |
| <input type="checkbox"/> Funeral | <input type="checkbox"/> Optometry | <input type="checkbox"/> Speech/Hearing |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy) | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM)) | | <input type="checkbox"/> Texas Hold'em Individual |

Print your current full name:

Last Name

First Name

Middle Initial

Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

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

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.