APPLICATION FOR PHYSICIAN LICENSE TO PRACTICE MEDICINE
INSTRUCTION SHEET

Please read these instructions carefully. Failing to follow instructions may delay your licensure.

Guidelines for Submitting Your Application Packet

As the applicant, you are responsible for submitting a complete application packet to the Board office. We will not process your application until we receive all required items as explained on the checklist below. If your application packet is not complete within three months of filing, we will consider it abandoned and discard your application form and other documents received.

Obtain the required items listed below from the third party sources and submit them all together in a single packet to the Board office unless the instructions state that the third party sources will send the items directly to the Board office. When enclosing items from third party sources in your packet, send

- **originals** – not copies – of the items
- **envelopes** in which you received the items

Requirements for All Applicants

Your application packet must include all of the following:

- Enclose this instruction sheet with the applicable checklists completed.

- Submit completed, signed and notarized Application for Physician License to Practice Medicine form.
  - Make sure all questions are answered unless the instructions tell you to skip a question.
  - Read the AFFIDAVIT section.
  - Sign the application in front of a notary public.

- Enclose the non-refundable processing fee by check or money order made payable to “State of Delaware.”

- If you ever held a medical or training license in any jurisdiction other than Delaware, a license verification from each jurisdiction where you have held a license is required. However, you will submit some verifications in your application packet, while others will come directly from the jurisdiction to the Board office. Read the following information about requesting verifications carefully:
  - If a jurisdiction utilizes VeriDoc to process license verifications, you must request the verification from VeriDoc, not from the jurisdiction. VeriDoc will send the verification directly to the Board office, not to you. For a list, click VeriDoc Participating States.
  - If you have ever held an Indiana license, request a digitally certified verification at http://www.in.gov/pla/verify.htm. The site will download a verification in pdf format to your computer. Print the pdf document and send it in your packet. Contrary to the instruction on Indiana’s site, please do not email the pdf document to the Board office unless the Board office asks you to do so.
  - For all other jurisdictions, request the jurisdiction to send the verification to you and include it in your packet.
    o You may use the Verification of Physician License form included with this application form to request the verification.
    o You may wish to obtain an AMA Profile or AOA Profile in order to make sure that you request verifications of all licenses that you have ever held.
    o Before requesting a verification, check whether the jurisdiction requires a fee.
    o The jurisdiction’s seal must be affixed to the form.
    o Remember to enclose the envelope in which you received the verification from the third party source.
  - Verifications that you print off the internet or receive by fax will not be accepted.
Unless an exception listed below applies, obtain a Service Letter from each healthcare facility where you currently have, or had within the past three years, either direct patient access or admitting or staff privileges.

- **A responsible physician at the facility must sign the form.**
- Remember to enclose the envelopes in which you received each Service Letter.
- You do not have to provide a Service Letter for the following practice situations:
  - You were practicing as an intern, resident, fellow, or house physician for the past three years.
  - Your practice for the past three years was via telemedicine with no direct patient access.
  - You were a locum tenens with no direct patient access for the past three years.

If you are currently in training, submit a signed letter from the program director of your training institution on the institution’s letterhead. It must state that you have successfully completed your first year of training and the anticipated date you will complete your training.

If any of the following describes your situation, obtain two letters of reference from physicians who are familiar with you but are not related to you:

- You have practiced only as an intern, resident, fellow or house physician, or
- You were self-employed for the entire past three years, or
- You had no direct patient access during the past three years, or
- One or more of the facilities where you had direct patient access in the past three years no longer exists.

If you answer “yes” to questions in the DISCLOSURES section – other than Questions 31, 33, 34 – you must fully explain your answer. We suggest that you use the Physician Self-Report form for this purpose. However, if the Physician Self-Report does not fully cover your situation, submit a signed, notarized statement in lieu of or in addition to the Physician Self-Report.

Request a self-query from the National Practitioner Data Bank (NPDB) website at [www.npdb.hrsa.gov](http://www.npdb.hrsa.gov). The self-query report will be mailed to your address. When you receive the report, enclose the original report in your application packet.

If you have never been issued a U.S. Social Security Number (SSN), complete 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.

In addition, arrange for the Board office to receive the following documents directly from the third party sources.

- 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. The State Bureau of Identification will send the report directly to the Board office.
  - Date requested: ______________

- Complete, sign and submit the Delaware Child Protection Registry Request Form to the Department of Services for Children, Youth & Their Families (DSCYF) following the instructions on the form. DSCYF will send the report directly to the Board office.
  - Date requested: ______________

- If a jurisdiction where you have ever held a medical or training license utilizes VeriDoc to process their license verifications, request the verification from VeriDoc, not from the jurisdiction. VeriDoc will send the verification directly to the Board office. For a list, click VeriDoc Participating States.
  - Date requested: ______________

**Additional Requirement for FCVS Applicants**

Delaware accepts the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards (FSMB). If you are using the FCVS service, the following requirement applies in addition to the items listed in Requirements for All Applications above:

- Request your Physician Information Profile from FCVS at [www.fsmb.org/fcvs_physapp.html](http://www.fsmb.org/fcvs_physapp.html). FCVS will send the profile directly to the Board office.
  - Date requested: ______________
Additional Requirements for Non-FCVS Applicants

If you are not using the FCVS service, the application packet that you submit must include all of the following in addition to the items listed in Requirements for All Applications above:

☐ Submit an 8 1/2" X 11” copy of your medical school diploma.
  • If you are a foreign medical graduate, attach an English translation from a reputable translating organization.

☐ Obtain a Verification of Medical Education from each medical school you attended.
  • The school’s seal must be affixed to the form. If no seal is available, the form must be notarized.
  • Internet verifications or faxed verifications will not be accepted.

☐ If you graduated from a foreign medical school, submit 8 1/2" X 11” copy of your current and valid Educational Commission for Foreign Medical Graduates (ECFMG) certificate.

☐ Submit an 8 1/2" X 11” copy of your Postgraduate Education Training Certificate(s).
  • Only training programs are those that have been approved by the Accreditation Council for Graduate Medical Education will be accepted.
  • If you graduated from a program approved by the American Medical Association (AMA) or American Osteopathic Association (AOA) in the U.S. (or U.S. territory) or Canada, you must have completed one year of postgraduate training in the U.S.
  • If you did not graduate from an AMA- or AOA-approved program, you must have completed three years of postgraduate training in the U.S.

☐ Obtain a Verification of Post Graduate Medical Education form from each program that you attended.
  • The program’s seal must be affixed to the form. If no seal is available, the form must be notarized.
  • Internet verifications or faxed verifications will not be accepted.

☐ Obtain a complete examination history, including all passing and failing attempts, from the following organizations:
  • Federal Licensing Examination (FLEX), United States Medical Licensing Examination (USMLE), and Special Purpose Examination (SPEX) examinations administered by the Federation of State Medical Boards – Request report at www.fsmb.org.
  • National Board of Medical Examiners (NBME) examination administered by the National Board of Medical Examiners – Request report at www.nbme.org.
  • National Board of Osteopathic Medical Examiners (NBOME) Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) examinations administered by the National Board of Osteopathic Medical Examiners. Request report at www.nbome.org
  • Qualifying Examination (QE) Part I and Part II conducted by the Medical Council of Canada for the purpose of awarding the “Licentiate of the Medical Council of Canada” (LMCC). Request report at www.mcc.ca.

Controlled Substance Registration

• The application for Physician licensure is NOT an application for a controlled substance registration (CSR). For the CSR application and instructions, see Application for Controlled Substances Registration – Practitioners.

• If you apply for your Physician license and CSR at the same time, the Controlled Substance application will be processed after your Physician license is issued. When your Delaware CSR is approved, you must then file for a federal DEA registration.
APPLICATION FOR PHYSICIAN LICENSE TO PRACTICE MEDICINE

TYPE OF APPLICATION

1. I am applying for Physician licensure as a:
   - [ ] MD – I received my medical education: [ ] in the U.S.  [ ] outside the U.S.
   - [ ] DO

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

IDENTIFYING AND CONTACT INFORMATION

3. Full Name: __________________________________________ ______________________________ _________________________________
   Last/Family    First    Middle

4. Other Names Used: _______________________ ________________________ ______________________  None [ ]

5. Date of Birth (month/day/year): ______________  Gender:  Male [ ] Female [ ]

6. Do you have a U.S. Social Security Number?  [ ] Yes  [ ] No  If yes, enter your SSN: _______________________
   If no, you must file a Request for Exemption from Social Security Number Requirement.

7. Mailing Address: __________________________________________________________________________________________________________
   ___________________________________________________ ______________________________ ____________________
   City       State                     Zip

8. Phone: _____________________  __________________   Email: _____________________________________ None [ ]
   Home or cell         Work

MEDICAL EDUCATION

9. Enter complete information about your medical education.

<table>
<thead>
<tr>
<th>SCHOOL NAME</th>
<th>LOCATION</th>
<th>DATES ATTENDED</th>
<th>DEGREE RECEIVED</th>
</tr>
</thead>
<tbody>
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</table>

If you are not using FCVS, submit an 8 1/2” X 11” copy of your medical school diploma and a Verification of Medical Education form from each medical school.

10. Did you graduate from a foreign medical school?  [ ] Yes  [ ] No  If yes, enter your USMLE/ECFMG Identification Number: 0-__________________________
    If you are not using FCVS, submit 8 1/2” X 11” copy of your ECFMG certificate.
POST-GRADUATE TRAINING

11. Enter complete information about all your post-graduate training, to include fellowships or specialty trainings. If you need more room, enclose a separate sheet with the same information.

<table>
<thead>
<tr>
<th>HOSPITAL/INSTITUTION</th>
<th>LOCATION</th>
<th>DATES OF TRAINING</th>
<th>SPECIALTY</th>
<th>DOES FACILITY STILL EXIST?</th>
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<td>Yes ☐ No ☐</td>
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<td>Yes ☐ No ☐</td>
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If you are currently in training, submit a signed letter from the program director of your training institution on the institution’s letterhead. It must state that you have successfully completed your first year of training and the anticipated date you will complete your training.

If you are not using FCVS, submit an 8 1/2” X 11” copy of your Postgraduate Education Training Certificate(s) and a Verification of Post Graduate Medical Education form from each program.

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

<table>
<thead>
<tr>
<th>AREA/FIELD</th>
<th>ARE YOU BOARD ELIGIBLE?</th>
<th>ARE YOU BOARD CERTIFIED?</th>
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<tbody>
<tr>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
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<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
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EXAMINATION HISTORY

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

- ☐ ECFMG (Basic) If passed, date: __________________
- ☐ ECFMG (Clinical) If passed, date: __________________
- ☐ ECFMG (English) If passed, date: __________________
- ☐ Flex Component 1 If passed, date: __________________
- ☐ Flex Component 2 If passed, date: __________________
- ☐ Pre-1985 Flex If passed, date: __________________
- ☐ USMLE Step 1 If passed, date: __________________
- ☐ USMLE Step 2 If passed, date: __________________
- ☐ USMLE Step 3 If passed, date: __________________
- ☐ NBME Part 1 If passed, date: __________________
- ☐ NBME Part 2 If passed, date: __________________
- ☐ NBME Part 3 If passed, date: __________________
- ☐ NBOME Part 1 If passed, date: __________________
- ☐ NBOME Part 2 If passed, date: __________________
- ☐ NBOME Part 3 If passed, date: __________________
- ☐ SPEX If passed, date: __________________
- ☐ COMLEX Level 1 If passed, date: __________________
- ☐ COMLEX Level 2 If passed, date: __________________
- ☐ COMLEX Level 3 If passed, date: __________________
- ☐ LMCC If passed, date: __________________
- ☐ State Board Examination State: __________________ If passed, date: __________________

If you are not using FCVS, submit complete examination histories, including all passing and failing attempts, from the organization.
LICENSURE HISTORY

14. Have you ever held a medical license issued by another jurisdiction (state, U.S. territory or District of Columbia)?
   Yes ☐ No ☐ If yes, list each jurisdiction where you now hold, or have ever held, a medical license, including
   training licenses. If you need more room, enclose an additional sheet with the same information.

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>LICENSE NUMBER</th>
<th>ISSUE DATE</th>
<th>EXPIRATION DATE</th>
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A license verification from each jurisdiction where you have held a license is required. This applies whether
or not you are using FCVS. See the Instruction Sheet for details on how to submit license verifications.

PRACTICE HISTORY

15. Have you ever practiced medicine other than as an intern, resident, fellow or house physician? Yes ☐ No ☐ If yes,
    continue with the next question. If no, obtain two letters of reference from physicians who are familiar with
    you but are not related to you AND skip to the DISCLOSURES section.

16. During the past three years, have you practiced medicine only as a locum tenens with no direct patient access or
    only via telemedicine with no direct patient access? Yes ☐ No ☐ If yes, obtain two letters of reference from
    physicians who are familiar with you but are not related to you AND skip to the DISCLOSURES section.

17. Did you have any direct patient access during the past three years? Yes ☐ No ☐ If no, obtain two letters of
    reference from physicians who are familiar with you but are not related to you AND skip to the DISCLOSURES
    section.

18. Were you self-employed for the entire past three years? Yes ☐ No ☐ If yes, obtain two letters of reference from
    physicians who are familiar with you but are not related to you AND skip to the DISCLOSURES section.

19. List each healthcare facility where you currently have, or had within the past three years, either direct patient access
    or admitting or staff privileges. If you need more room, enclose a separate sheet with the same information.

<table>
<thead>
<tr>
<th>FACILITY NAME</th>
<th>ADDRESS</th>
<th>AFFILIATION DATES</th>
<th>DOES THIS FACILITY STILL EXIST?</th>
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<td>From          To</td>
<td>Yes ☐ No ☐</td>
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</table>

Obtain a Service Letter from each listed healthcare facility that still exists. In addition, if any of the listed
facilities no longer exists, obtain two letters of reference from physicians who are familiar with you but are
not related to you.
DISCLOSURES

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

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

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

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

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

   Request a self-query from the NPDB. When you receive the report, enclose the original report in your application packet. This applies whether or not you are using FCVS.

24. Has a hospital, related health care facility, HMO, or alternative health care system ever:
   • denied your application for privileges or failed to renew your privileges? Yes □ No □
   • limited, restricted, suspended, or revoked your privileges in any way (including during your training program)? Yes □ No □

25. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes □ No □ *If yes, provide a copy of any documents in your possession related to the final disposition of the investigation and continue with the next question. If no, skip to Question 27.*

26. Do you agree to sign an authorization for the Board of Medical Licensure and Discipline and the Division of Professional Regulation to obtain any and all information concerning the disposition of the investigation directly from the licensing authority, medical association, hospital or other healthcare institution? Yes □ No □

27. Have any charges or complaints of any kind, such as malpractice claims, ever been filed against you? (Include any that are currently pending against you.) Yes □ No □

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

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

30. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any of the following:
   • administrative or judicial proceedings or investigation? Yes □ No □
   • inquiry or other proceeding? Yes □ No □
   • proposed termination by an educational institution, employer, governmental agency, professional organization, or licensing authority? Yes □ No □

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

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

32. Do you have a mental or physical disability that limits your ability to practice medicine in a fully competent and professional manner with safety to patients? Yes □ No □ *If yes, continue with the next question. If no, skip to Question 34.*

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

DUTY TO REPORT

35. To obtain a license in Delaware, you must certify that you understand that you have a mandatory obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner other than yourself is (or may be) guilty of unprofessional conduct as defined in 24 Del. C. §1731 OR that he/she is (or may be):
   • medically incompetent
   • mentally or physically unable to engage safely in the practice of medicine
   • excessively using or abusing drugs including alcohol.

   I certify that I have read and understand the provisions of 24 Del. C. §1730, 24 Del. C. §1731 and 24 Del. C. §1731A and that I understand my duty to report. Yes ☐ No ☐

36. To obtain a license in Delaware, you must certify that you understand that you have a mandatory obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

   I certify that I have read and understand 16 Del. C. §903 and that I understand my duty to report. Yes ☐ No ☐

37. To obtain a license in Delaware, you must certify that you understand that you have a mandatory obligation to self report all of the following:
   • Any change in hospital privileges and any disciplinary action taken by any medical society against you within 30 days (24 Del. C. §1730(b)(1))
   • Any civil or criminal investigation in any jurisdiction which concerns your certification or license or other authorization to practice medicine within 30 days (24 Del. C. §1730(b)(2))
   • All information concerning medical malpractice claims settled or adjudicated to final judgment, as provided in Chapter 68 of Title 18, within 60 days. (24 Del. C. §1730 (c))
   • Each final judgment, settlement, or award against you regardless whether you have malpractice insurance, within 30 days of the final judgment, settlement, or award. (24 Del. C. §1731A (f))
   • Any reports filed against you with the Department of Services for Children, Youth and Their Families under Chapter 9 of Title 16 concerning child abuse or neglect (24 Del. C. §1730 (d))
   • Any reports filed against you to the Division of Long Term Care Residents Protection under Chapter 85 of Title 11 concerning adult abuse, neglect, mistreatment or financial exploitation (24 Del. C. §1730 (d))

   I certify that I have read and understand all of provisions in the Delaware Medical Practice Act, including those listed above, and understand my duty to self report. Yes ☐ No ☐

   Complete, sign and submit the Delaware Child Protection Registry Request Form to the Department of Services for Children, Youth & Their Families (DSCYF) following the instructions on the form. DSCYF will send the report directly to the Board office.
The Board office must receive all of these items no later than 4:30 PM ten full working days before the Board’s next meeting date in the event that your application requires Board review:

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

If your application packet is not complete within three months of filing, we will consider it abandoned and discard your application form and all other documents received. When your application packet is complete, please allow 4-8 weeks to receive your license.

**AFFIDAVIT**

I swear all of the following:

- I am the person who executed this application.
- The statements contained on this application are true in every respect.
- I have not suppressed or withheld information that might affect this application.
- I will abide by the laws and the ethical standards of this profession.
- I have read and understand this statement.

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

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Board of Medical Licensure and Discipline any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or other pertinent data and to permit the Delaware Board of Medical Licensure and Discipline or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

I understand and acknowledge that the Delaware Board of Medical Licensure and Discipline will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to

- Keep the information in this application current until such time as the Board has finally acted on it, and
- Promptly provide any and all additional information requested by or on behalf of the Board.

**Signature of Applicant:** ______________________________________ Date: __________________

City of ___________________ County of _____________________________

Sworn to before me and subscribed in my presence this ______ day of __________________, 2______.

**Signature of Notary:** ____________________________________________

**SEAL**

My Commission Expires: ____________________________

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

Revised 9/2017
SERVICE LETTER

Instructions to Applicant: Obtain this form from each healthcare facility where you currently have, or had within the past three years, either direct patient access or admitting or staff privileges. Submit all forms in your application packet together with the envelopes in which you received each form.

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<tr>
<th>Release to be completed by Applicant</th>
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<tbody>
<tr>
<td>Healthcare Facility Name: ____________________________</td>
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<tr>
<td>Address: ____________________________________________</td>
</tr>
<tr>
<td>Applicant Last Name: __________________ First: ____________ Middle Initial: ___</td>
</tr>
<tr>
<td>Other Name(s) Used: __________________________ Birth Date: ______________</td>
</tr>
<tr>
<td>I authorize a full release permitting the Delaware Board of Medical Licensure and Discipline to obtain any and all information pertaining to the facts of my current or previous relationship with this facility.</td>
</tr>
<tr>
<td>Applicant Signature: ______________________________ Date: ______________</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Questions to be answered by Responsible Physician</th>
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<tbody>
<tr>
<td>1. What position did this applicant hold at your facility? ____________________________ from <em><strong>/</strong></em>/____ to <em><strong>/</strong></em>/____</td>
</tr>
<tr>
<td>2. Was the applicant placed on probation, suspended or in any way sanctioned/disciplined while at your facility? Yes ☐ No ☐</td>
</tr>
<tr>
<td>3. Was the applicant the subject of an investigation while at your facility? Yes ☐ No ☐</td>
</tr>
<tr>
<td>4. Did the applicant leave your facility in good standing? Yes ☐ No ☐</td>
</tr>
<tr>
<td>5. Would you recommend this applicant for privileges or consider rehiring this applicant at your facility? Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

If you answered “yes” to questions 2 or 3 or if you answered “no” to 4 or 5, please attach an explanation. You may also attach additional comments or information that the Board of Medical Licensure and Discipline should consider prior to determining this applicant’s eligibility for licensure. All attachments should be on your facility’s letterhead.

A health care facility that fails to make a full and complete disclosure of information shall be subject to a civil penalty of $10,000 for each such violation. Any health care facility providing information about an applicant as required by law shall be immune from claims, suits, liability, damages, or any other recourse, civil or criminal, so long as the person acted in good faith and without gross or wanton negligence. Good faith is presumed until proven otherwise, and gross or wanton negligence must be shown by the complaining. See 24 Del. C. §1730(b)(1)c and §1740(b).

I am licensed in the State of __________________________, License No___________________. I have known the applicant personally or professionally for the period ____/ ____/ ______ to _____/ _____/ ______.

Name of Responsible Physician: ____________________________ Title: ____________________________
Signature of Responsible Physician: ____________________________ Date: ____________________________
Phone: ______________ Fax: ______________ Email: ____________________________

If no a seal or notary is available attach a statement on facility letterhead and check here: ☐

Mail (do not fax) completed, signed and sealed form to the applicant above.

Revised 9/2017
Instructions to Applicant: You may use this form to obtain a license verification from each jurisdiction where you have ever held a license to practice medicine. Do not use this form for VeriDoc participating jurisdictions or Indiana verifications. Submit all forms in your application packet together with the envelopes in which you received each form.

| Licensing Authority: ________________________________ | Applicant Name: ________________________________ |
| Address: __________________________________________ | Home Address: _________________________________ |
| City/State/Zip: ____________________________________ | City/State/Zip: ________________________________ |

This section to be completed by Applicant

Last Name: ________________________________ First: ________________________________ Middle: ________________________________
SSN: ________________________________ DOB: ________________________________
Other Name(s) Used: ____________________________________________________________
License Number(s) in Jurisdiction Named Above: ________________________________

I am applying for licensure as a Physician in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to the Delaware Board of Medical Licensure and Discipline.

This includes any medical training licenses.

Applicant Signature: ________________________________ Date: ________________________________

This section to be completed by Licensing Authority

Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of ________________________________ License Number: ________________________________
Issue Date (month/day/year): ________________________________ Expiration Date (month/day/year): ________________________________

Has any discipline activity taken place regarding this licensee? Yes ☐ No ☐ If yes, please enclose a certified copy of the Board Order with this license verification.

CERTIFICATION
AFFIX OFFICIAL SEAL OR NOTARY 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 to the applicant above.
### Instructions for Applicant

If you are not using the FCVS service, obtain this form from each medical school attended. Submit all forms in your application packet together with the envelopes in which you received each form.

<table>
<thead>
<tr>
<th>Educational Institution: ____________________________</th>
<th>Applicant Name: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: ____________________________</td>
<td>Home Address: ________________________________</td>
</tr>
<tr>
<td>City/State/Zip: __________________</td>
<td>City/State/Zip: __________________</td>
</tr>
</tbody>
</table>

**This section to be completed by Applicant**

<table>
<thead>
<tr>
<th>Last Name: __________________</th>
<th>First: __________________</th>
<th>Middle: __________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSN: __________________</td>
<td>Birth Date: ______________</td>
<td></td>
</tr>
<tr>
<td>Other Name(s) Used: ______________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Applicant Signature: __________________ Date: ________________ |

**This section to be completed by Institution**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>FROM (month/day/year)</th>
<th>TO (month/day/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Was the applicant awarded a degree?  
   - Yes [ ]  
   - No [ ]

   - If yes, enter: 
     Degree Received: __________________ Date Degree Conferred (month/day/year): ______________
   - If no, 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.

<table>
<thead>
<tr>
<th>Printed Name of Institution Official: __________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Official: __________________ Date: ______________</td>
</tr>
<tr>
<td>Title: __________________</td>
</tr>
<tr>
<td>Phone: __________________ Fax: __________________ Email: __________________</td>
</tr>
</tbody>
</table>

Mail (do not fax) completed, signed and sealed form to the applicant above.
**VERIFICATION OF POST-GRADUATE MEDICAL TRAINING**

Instructions for Applicant: If you are not using the FCVS service, obtain this form from each program attended. Submit all forms in your application packet together with the envelopes in which you received each form.

<table>
<thead>
<tr>
<th>Educational Institution: ___________________________</th>
<th>Affiliated University: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: _________________________________________</td>
<td>Address: _________________________________________</td>
</tr>
<tr>
<td>City/State/Zip: __________________________________</td>
<td>City/State/Zip: __________________________________</td>
</tr>
</tbody>
</table>

This section to be completed by Applicant

<table>
<thead>
<tr>
<th>Last Name: ___________________________</th>
<th>First: ___________________________</th>
<th>Middle: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSN: ___________________________</td>
<td>DOB: ___________________________</td>
<td>Other Name(s) Used: ___________________________</td>
</tr>
</tbody>
</table>

Program Participation to be completed by Institution

<table>
<thead>
<tr>
<th>PGY Year: ________</th>
<th>Department: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internship</td>
<td>From (month/day/year): ____________ To (month/day/year): ____________</td>
</tr>
<tr>
<td>Residency</td>
<td>Successfully completed? Yes □ No □ In Progress □</td>
</tr>
<tr>
<td>Fellowship</td>
<td>Accreditation: ACGME □ AOA □ Not Accredited □ Other □ Explain: ___________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PGY Year: ________</th>
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<td>Fellowship</td>
<td>Accreditation: ACGME □ AOA □ Not Accredited □ Other □ Explain: ___________________________</td>
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</tbody>
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<th>PGY Year: ________</th>
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</tr>
<tr>
<td>Fellowship</td>
<td>Accreditation: ACGME □ AOA □ Not Accredited □ Other □ Explain: ___________________________</td>
</tr>
</tbody>
</table>

Questions to be completed by Institution

1. Did this applicant ever take a leave of absence or break from training? Yes □ No □
2. Was this applicant ever placed on probation? Yes □ No □
3. Was this applicant ever disciplined or placed under investigation? Yes □ No □
4. Did the instructors file any negative reports on this applicant? Yes □ No □
5. Were any limitations or special restrictions placed on this applicant because of questions of academic incompetence, disciplinary problems or any other reasons? Yes □ No □

Explain yes answers and any other unusual circumstances on a separate sheet.

CERTIFICATION

I certify that the information above is an accurate account of this individual’s records and is true and correct.

Print Name of Program Director (MD or DO): ___________________________

Signature of Program Director: ___________________________ Date: ____________

Phone: ___________________________ Fax: ___________________________ Email: ___________________________

*Mail (do not fax) completed, signed and sealed form to the applicant 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
(by 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.

Revised 9/2017
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:

☐ Adult Entertainment  ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
☐ Charitable Gaming Vendor  ☐ Nursing (RN, LPN, APRN)
☐ Chiropractic  ☐ Nursing Home Administrator
☐ Dental  ☐ Occupational Therapy
☐ Funeral  ☐ Optometry
☐ Massage  ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
☐ Podiatry
☐ Psychology
☐ Real Estate Appraiser (includes Appraisal Management Company)
☐ Speech/Hearing
☐ Social Work
☐ 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.

Revised 9/2017
DELAWARE CHILD PROTECTION REGISTRY REQUEST FORM

Fax or Mail Request to: OCCL, Criminal History Unit
Concord Plaza, Hagley Building
3411 Silverside Road
Wilmington, DE 19810
Phone: 302-892-5800  Fax: 302-633-5191

When requesting Child Protection Registry checks:
• Allow 15 working days for results to be processed.
• Do not use a cover sheet.
• Do not send duplicate requests.
• Form must be submitted to DSCYF within 90 days of signature date in order to be processed.

PART I. APPLICANT INFORMATION – Type or print clearly.

Name: ____________________________________ ________________________ ______________________________
Last                      First                        Middle
Other Name(s) Used: ______________ ________________ ______________ DE Drivers License #: ________________
Social Security #: _____- ____ - _____ Date of Birth: ___ / ___ / ______ 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

Please check only one:
☐ EDUCATION  ☐ HEALTH CARE 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: Nicole Williams

DSCYF USE ONLY

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

Revised 9/2017
The Physician’s mandatory duty to self-report is in 24 Del C. § 1730 and § 1731A. To comply with your duty, complete and submit this form to the Board of Medical Licensure and Discipline within the required time limit. You may duplicate the form.

IDENTIFYING AND CONTACT INFORMATION

1. Physician Name: _______________________________ _______________________________ _______________________________
   Last     First        Middle

2. Delaware License Number: C ___ - _______________________

3. Mailing Address: _______________________________________________________________________________
   ___________________________ ______________________ _____________
   City       State   Zip

4. Office Phone: _____________________________   Email: ____________________________________________

MALPRACTICE COMPLAINT

5. Plaintiff Name: ______________________________________________ Age:  ___________ Sex: ______________

6. Address of Record: __________________________________________________________________________________

7. Date of Occurrence: __________________

8. Place of Occurrence (office, hospital name & address): _________________________________________________

9. What was your position in case (e.g., resident, primary physician)? ________________________________________

10. Who was the complaint filed against? ☐ Individual Doctor ☐ Group ☐ Hospital

11. Names of other defendant-doctors and/or hospitals: ___________________________________________________
   _______________________________________________________________________________________________

DISPOSITION

12. What was the disposition? ☐ Verdict ☐ Settled

13. Final Disposition: ______________________________________________________________________________ Date: __________________

14. Civil Case No.: _____________________________ Attorney: ___________________________________________

15. Total Amount Paid (if any): __________________

16. Amount Attributable to You: __________________

17. Insurance Company Covering You for this Incident: _________________________________________________

Signature: __________________________________________________Date: _______________

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

Revised 9/2017