APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT
INSTRUCTION SHEET

Please read all instructions carefully. Failing to follow instructions may delay your licensure. If your application is not complete within six months of filing, it may be considered abandoned and discarded.

Physician Assistant Prescriptive Authority

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

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

Requirements for All Applications

☐ Submit completed, signed and notarized Application for Licensure as a Physician Assistant.
  - 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."

☐ 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.

☐ If you now hold, or have ever held, a PA license in any jurisdiction (state, U.S. territory or District of Columbia) other than Delaware, arrange for the Board office to receive a Verification of Physician Assistant License form from each jurisdiction where you have held a license.
  - Before forwarding the form, check whether the jurisdiction requires a fee.
  - The Board office must receive the completed verification directly from the other jurisdiction. The jurisdiction’s seal must be affixed to the form.
  - Internet verifications or faxed verifications will not be accepted.

☐ Request a self-query from the National Practitioner Data Banks (NPDB) website at www.npdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, mail (do not fax) the original report to the Board office.

☐ Complete, sign and submit the Delaware Child Protection Registry Request Form to the Department of Services for Children, Youth & Their Families following the instructions on the form.
If you have never been issued a U.S. Social Security Number (SSN), submit a Request for Exemption from Social Security Number Requirement. The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

Additional Requirement for FCVS Applicants

Delaware accepts the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards (FSMB). For more information, see http://www.fsmb.org/fcvs_paapp.html.

Arrange for the Board office to receive your Physician Assistant Information Profile from FCVS.

Additional Requirements for Non-FCVS Applicants

Submit an 8" X 11 1/2" copy of your Physician Assistant diploma.

Arrange for the Board office to receive a Verification of Physician’s Assistant Education form from the PA program from which you graduated.
- The program from which you graduated must be AMA-approved.
- The Board office must receive the completed form directly from the school. The school’s seal must be affixed to the form. If no seal is available, the form must be notarized.
- Internet verifications or faxed verifications will not be accepted.

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

Additional Continuing Medical Education Requirement

The following requirement pertains only when
- you hold a current PA license in another jurisdiction or you are reapplying for Delaware PA licensure that lapsed
- your CME within the past two years is current.

Submit proof of 100 hours of continuing medical education (CME), consisting of 50 hours of AMA Category I CME (Section 13.2.2 of the Board’s Rules and Regulations).

Temporary Licensure

The temporary permit allows you to practice until you have passed the Physician Assistant National Certifying Examination (PANCE) and your permanent license is issued. You may be granted a temporary license if you
- have graduated from an accredited PA program and otherwise meet all the requirements for licensure except for passing the PANCE, and
- have registered to take the next available PANCE.

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

To apply for a temporary permit...

Answer “yes” to Question 3 on the application form.

Enclose the temporary license fee by check or money order made payable to “State of Delaware.”
- This fee is in addition to the processing fee for your application. However, you may combine the fees in one check or money order.
Important Information about Controlled Substance Registrations

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

- Delaware PA license with prescriptive authority
- At least one supervising physician for each individual business/practice where you practice in Delaware
- Delaware CSR
  
  Note: If you practice at more than one business/practice, you need only a single CSR to prescribe at all of the locations. However, every Delaware location where controlled substances are dispensed/stored must be covered by a CSR. If no other practitioner (e.g., physician), physician assistant or APN holds a Delaware CSR for a location where you will store/dispense, as well as prescribe, controlled substances, you must file for an additional CSR for the location.

- Federal DEA registration for Delaware (a DEA registration in another jurisdiction is not sufficient)

To apply for a CSR(s), see Controlled Substances Application for Advanced Practice Nurses, available on dpr.delaware.gov. For Federal DEA registration, see DEA New Registration Applications.
APPLICATION FOR LICENSURE AS A PHYSICIAN ASSISTANT

TYPE OF APPLICATION

1. Select the item that describes your situation (check one):
   - [ ] I have never held a PA license in any jurisdiction and am applying on the basis of the Physician Assistant National Certifying Examination (PANCE).
   - [ ] I hold a current, active PA license in another jurisdiction.
   - [ ] I am re-applying because my Delaware PA license has lapsed. My license number was: C5 - ________________

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

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

4. Are you also applying for Prescriptive Authority?  Yes [ ] No [ ]
   - [ ] Non-Controlled Substances Only
   - [ ] Both Controlled and Non-Controlled Substances

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

IDENTIFYING AND CONTACT INFORMATION

5. Full Name: ________________________________________________
   Last           First           Middle

6. Other Names Used: None [ ] ________________________________

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

8. Have you been issued a U.S. Social Security Number?  Yes [ ] No [ ]
   - If yes, enter the SSN: _________________
   - If no, you must file a Request for Exemption from Social Security Number Requirement.

9. Mailing Address: _______________________________________________________________________________
   ___________________________________________________ ___________________________ ____ ____________
   City      State           Zip

10. Phone: ____________________  ____________________ Email: _________________________________ None [ ]
    Home              Work

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

11. Are you a graduate of an AMA-approved PA program? Yes [ ] No [ ]
    - If yes, enter this information:
      Institution Name: ________________________________________________
      Graduation Date: ________________
      Address: _______________________________________________________
      Street     City              State              Zip

    If you are not using FCVS, submit an 8 1/2" X 11" copy of your Physician Assistant diploma and arrange for the Board office to receive a Verification of Physician’s Assistant Education form from the PA program, sent directly from the school(s).

Revised 9/2017
12. Have you ever been deemed ineligible to sit for a PA national certifying examination for any reason? Yes ☐ No ☐
   If yes, explain: __________________________________________________________________________________

13. Are you certified by the National Commission on Certification of Physician Assistants (NCCPA)? Yes ☐ No ☐
   If yes, enter the following information about your certification and skip to the Continuing Medical Education section:
   Certification Number: __________________________ Date of Certification: ________________
   If you are not using FCVS, arrange for the Board office to receive an official Verification of Certification sent
directly from NCCPA to the Board office.

14. Have you taken the national certifying examination? Yes ☐ No ☐
   • If yes, enter the date you sat for the exam: ______________
   • If no, enter the date of the exam for which you have registered: __________________________

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

15. Do you currently log continuing medical education (CME) with a nationally recognized agency? Yes ☐ No ☐
   If yes, check agency:  
   □ NCCPA  □ AAPA  □ Other – Enter agency: __________________________

16. Within the past two years, have you completed at least 100 hours of CME, 50 of which are Category I CME? Yes ☐ No ☐
    If yes, submit proof of your current CME.

LICENSURE HISTORY – All applicants complete this section.

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

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

<table>
<thead>
<tr>
<th>JURISDICTION</th>
<th>LICENSE NUMBER</th>
<th>EXPIRATION DATE</th>
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Arrange for the Board office to receive a Verification of Physician Assistant License form from each
jurisdiction where you have held a license. This applies whether or not you are using FCVS.

19. Have you engaged in clinical practice as a physician assistant within the past three years? Yes ☐ No ☐

DISCLOSURES – All applicants complete this section. If a question in this section directs you to submit a signed
statement to explain your answer, the statement should specify where and when the incident occurred, issues
involved and any further information you wish to provide.

20. Have you ever been disciplined or had formal written action taken by a hospital staff or medical society, or licensing
board of another jurisdiction? Yes ☐ No ☐ If yes, submit a signed statement explaining fully.
   Request a self-query from the National Practitioner Data Bank (NPDB) and, when you receive the report, mail
   the original to the Board office.

21. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other
healthcare institution? Yes ☐ No ☐ If yes, submit a signed statement explaining fully and a copy of any
documents in your possession related to the final disposition of the investigation. Continue with the next
question. If no, skip to Question 23.
22. 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 ☐

23. Within the past two years, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as a physician assistant, including use or abuse of dangerous or addicting substances? Yes ☐ No ☐ If yes, submit a signed statement explaining fully. Continue with the next question. If no, skip to Question 25.

24. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes ☐ No ☐

25. Within the past two years, have you engaged in the illegal use of controlled dangerous substances? Yes ☐ No ☐ If yes, submit a signed statement explaining fully.

26. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes ☐ No ☐ If yes, submit a signed statement explaining fully.

**DUTY TO REPORT** – All applicants complete this section.

27. 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 ☐

28. 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 ☐

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

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

Complete, sign and submit the Delaware Child Protection Registry Request Form to the Department of Services for Children, Youth & Their Families following the instructions on the form.
PRESCRIPTIVE AUTHORITY – Complete this section only if you answered “Yes” to Question 4 (applying for prescriptive authority).

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

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

________________________________ ______________________________ ____________________________
________________________________ ______________________________ ____________________________
________________________________ ______________________________ ____________________________
________________________________ ______________________________ ____________________________
________________________________ ______________________________ ____________________________
________________________________ ______________________________ ____________________________
________________________________ ______________________________ ____________________________

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

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

Additional Statements on next page
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The Board office must receive all of these items no later than 4:30 PM ten full working days before the Council’s next meeting date in the event that your application requires the Council’s review:

- 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 permanent Physician Assistant license.

AFFIDAVIT

I swear all of the following:

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

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

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

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

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

Signature of Applicant: ________________________________ Date: ________________

City of ___________________ County of ________________________________

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

Signature of Notary: ____________________________________________

SEAL

My Commission Expires: ________________________________________

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.
Instructions for Requesting a Criminal Background Check

Both State 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](http://www.fbi.gov) 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
- Charitable Gaming Vendor
- Chiropractic
- Dental
- Funeral
- Massage
- Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- Nursing (RN, LPN, APRN)
- Nursing Home Administrator
- Occupational Therapy
- Optometry
- Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- Podiatry
- Psychology
- Real Estate Appraiser (includes Appraisal Management Company)
- Speech/Hearing
- Social Work
- Texas Hold’em Individual
- Physical Therapy/Athletic Trainer

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
VERIFICATION OF PHYSICIAN ASSISTANT LICENSE

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

| Licensing Authority: ____________________________ | Applicant Name: ____________________________ |
| Address: _______________________________________ | Home Address: ________________________________ |
| City/State/Zip: ________________________________ | City/State/Zip: ________________________________ |

<table>
<thead>
<tr>
<th>This section is to be completed by applicant.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name: ____________________________  First: ____________________________  Middle: ____________________________</td>
</tr>
<tr>
<td>SSN: ____________________________  Date of Birth: ____________________________</td>
</tr>
<tr>
<td>Other Name(s) Used: __________________________________________________________________________</td>
</tr>
</tbody>
</table>

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

Applicant Signature: ____________________________  Date: ________________

<table>
<thead>
<tr>
<th>This section to be completed by Licensing Authority.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our records indicate that the applicant named above was licensed in the State/U.S. Territory of ____________________________ License Number: ____________________________</td>
</tr>
<tr>
<td>Issue Date (month/day/year): ___________________  Expiration Date (month/day/year): ___________________</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CERTIFICATION AFFIX OFFICIAL SEAL HERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of the following is certification that the information above is an accurate account of this individual’s records and is true and correct.</td>
</tr>
<tr>
<td>Printed Name of Official: ____________________________</td>
</tr>
<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 directly to the Board office at the address above.
VERIFICATION OF PHYSICIAN ASSISTANT EDUCATION

Physician Assistant applicants who are not using the FCVS service should send this form to the program from which graduated.

<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 is to be completed by applicant.

<table>
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<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>

I am applying for licensure as a Physician Assistant in the State of Delaware. Before my application can be reviewed, verification of my degree or certification is required. I am authorizing the release of the information requested on this form.

Applicant Signature: ______________________________________ Date: _________________

This section to be completed by Institution.

1. Enter the dates the applicant named above was enrolled in your institution:
   From (month/day/year): _____________ To (month/day/year): _____________

2. Was the applicant awarded a degree? Yes ☐ No ☐
   • If yes, enter:
     Degree Received: _____________ Date Degree Conferred (month/day/year): _____________
   • If no, attach explanation of reason applicant did not receive a degree.

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

Printed Name of Institution Official: ______________________________________

Signature of Official: ______________________________________ Date: _________________

Title: ______________________________________

Phone: ___________________ Fax: ___________________ Email: ___________________

Mail (do not fax) completed, signed and sealed form directly to the Board office at the address above.