CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
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STATE OF DELAWARE

BOARD OF MEDICAL LICENSURE AND DISCIPLINE

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

VERIFICATION OF DIRECTOR OF ACGME TRAINING PROGRAM

Instructions: Arrange for the Supervisor and/or Director of the Training Program for which you are employed as a Resident, Intern, Fellow or House Physician to complete this form.

1. Applicant Name: ______________________________ __________________________________ __________________
Last First Middle

2. Type of Employment/Training (check one): ☐ Intern ☐ Resident ☐ Fellow ☐ House Physician

Printed Full Name of Director of Training Program: ____

I verify that the above-named Resident/Intern/Fellow/House Physician will be employed or participating in a training program at ____ beginning __________________
Institution Name month/day/year
and that he/she will be under the supervision of a fully licensed physician in the State of Delaware. I further certify that the credentials of the Resident/Intern/Fellow/House Physician have been reviewed and approved. I understand that this license will expire on the day the applicant's employment with this institution ends, and I agree to notify the Board office no later than three days following the end of the employment relationship.

Signature of Director: ____ Date: _________________

Delaware Physician License Number: C ___ - ___________________

STATEMENT OF SUPERVISING PHYSICIAN

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

Printed Full Name of Supervising Physician: ____

***Signature of Supervising Physician*:** ____ Date: _______________

Delaware Physician License Number: C ___ - ___________________

UPLOAD THIS DOCUMENT WITH YOUR APPLICATION IN DELPROS

Revise 06/2020