



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

STATE OF DELAWARE  
**BOARD OF MEDICAL LICENSURE AND DISCIPLINE**

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

### STATEMENT OF CHIEF ADMINISTRATIVE OFFICER

Instructions: For renewal of the institutional certificate this form **must** be completed by the Chief Administrative Officer of the training program for which the licensee is employed as a Resident, Intern, Fellow or House Physician.

1. Licensee Name: \_\_\_\_\_  
Last First Middle
2. License Number: **C7** - \_\_\_\_\_
3. Type of Employment/Training (check one):  Intern  Resident  Fellow  House Physician

**The Chief Administrative Officer must complete and sign this section.**

1. You must certify that you understand that you are required to file a written report with the Board of Medical Licensure and Discipline if you have any reason to believe that a medical practitioner other than yourself is (or may be)
- medically incompetent
  - guilty of unprofessional conduct or
  - mentally or physically unable to engage safely in the practice of medicine (24 Del. C. §1731A).

I certify that I understand this *duty to report*. YES

2. I certify that this applicant will be employed by this facility and meets all the requirements for licensure specified in 24 Del. C. 1720(b) (1) through (b) (7), excluding (b) (3). YES

\_\_\_\_\_  
SIGNATURE OF CHIEF ADMINISTRATIVE OFFICER

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**UPLOAD THIS COMPLETED DOCUMENT WITH YOUR RENEWAL APPLICATION.**