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STATE OF DELAWARE

BOARD OF MEDICAL LICENSURE AND DISCIPLINE

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EMAIL: customerservice.dpr@delaware.gov

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. Upload all forms when you submit your application in DELPROS.

Release to be completed by Applicant	Healthcare Facility Name: ______________________ Address: ______________________ Applicant Last Name: ____________ First: ____________ Middle Initial: ____ Other Name(s) Used: ______________________ Birth Date: ____________ **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.** **Applicant Signature:** ______________________ Date: ____________
Questions to be answered by Responsible Physician	1. **What position did this applicant hold at your facility?** ______________________ **from** ____/____/______ **to** ____/____/______ 2. **Was the applicant placed on probation, suspended or in any way sanctioned/disciplined while at your facility? Yes** ☐ **No** ☐ 3. **Was the applicant the subject of an investigation while at your facility? Yes** ☐ **No** ☐ 4. **Did the applicant leave your facility in good standing? Yes** ☐ **No** ☐ 5. **Would you recommend this applicant for privileges or consider rehiring this applicant at your facility? Yes** ☐ **No** ☐ **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 complainant. 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:**____________________ **AFFIX OFFICIAL**

Signature of Responsible Physician: ______________________ **Date:** ____________ **SEAL OR**

Phone: ____________ **Fax:** ____________ **Email:**______________________ **NOTARY HERE**

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

UPLOAD THIS DOCUMENT WHEN YOU SUBMIT YOUR APPLICATION IN DELPROS.

Revised 4/2019