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
EMAIL: customerservice.dpr@delaware.gov

VERIFICATION OF RESPIRATORY CARE PRACTITIONER EDUCATION

Instructions: Arrange for each school you attended to complete this form. You must *upload* each completed form *before* you submit your application in DELPROS.

Educational Institution:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ Birth Date:_____ Other Name(s) Used: _____ **I am applying for licensure as a Respiratory Care Practitioner 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.
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.** **Printed Name of Institution Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:**_____ **Phone:** _____ **Fax:** _____ **Email:**_____

UPLOAD THIS DOCUMENT WHEN YOU SUBMIT YOUR APPLICATION.