



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@state.de.us

**APPLICATION FOR PHYSICIAN TRAINING LICENSURE
RESIDENTS, INTERNS, FELLOWS, HOUSE PHYSICIANS
INSTRUCTION SHEET**

When to Apply

File this application when you are a physician who is employed in an ACGME-approved *institution located in Delaware* and you are:

- a Resident, Intern or Fellow registered in a training program outside of Delaware who will rotate through a program in Delaware for over one month, **or**
- employed as a House Physician

For more information about Training licensure, see Section 4.0 of the Board's [Rules and Regulations](#).

Requirements for All Applicants

- Submit completed, signed and notarized [Application for Physician Training Licensure](#).
 - Both applicant and Director of Training Program/Supervising Physician must sign the application in front of the notary.
- Enclose the [processing fee](#) by check or money order made payable to "State of Delaware."
- If you answer "yes" to Questions 18 - 33 in the DISCLOSURES section, you must fully explain your answer. It is suggested that you use the [Physician Self-Report](#) form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, you may submit a signed, notarized statement in lieu of or in addition to the *Physician Self-Report*.
- 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 form to arrange to be fingerprinted.
 - You must meet this requirement *even if* you recently had a criminal background check done for some other reason.
- 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 Requirements for Fellows and House Physicians

If you are employed as a Fellow or House Physician, the following additional requirements apply.

- Submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s).
- If you are currently in training, submit a signed letter from the program director of your training institution on the institution's letterhead. It must state that you have successfully completed your first year of training and the anticipated date you will complete your training.



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IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____
Last First Middle
2. Other Names Used: None _____
(Include maiden, prior married, alternate spellings)
3. Date of Birth (month/day/year): _____ Gender: Male Female
4. Have you been issued a U.S. Social Security Number? Yes No **If yes, enter SSN:** _____
If no, you must file a [Request for Exemption from Social Security Number Requirement](#).
5. *Personal* Address: _____

City State Zip
6. Phone: _____ Home _____ Work _____ Email: None

INSTITUTION INFORMATION

7. Enter this information about the institution **in Delaware** where you will be employed/trained:
Name: _____ Department: _____
Mailing Address: _____
This is the address to which all correspondence, including your ACGME Training license, must be sent.

City State Zip
8. Start Date of Employment/Training (month/day/year): _____
9. Type of Employment/Training (check one): Intern Resident Fellow House Physician
10. Do you understand that you must limit yourself solely to practice within the hospital or to medical duties outside the hospital that are assigned to you as part of your internship or resident training program? Yes No

MEDICAL EDUCATION

11. Did you complete your medical education in the U.S. (including any state, U.S. territory or possession, District of Columbia)? Yes No **If yes, skip to Question 13.**
12. Were you a U.S. citizen when you enrolled in a medical school outside the U.S.? Yes No **If no, submit an 8 1/2" X 11" copy of your ECFMG certificate.**

13. Enter information about your medical school:

Name: _____ Graduation Date: _____

Location Address: _____

14. Are you applying as a Fellow or House Physician? Yes No If yes, enter complete information about your all post-graduate training. If no, skip to the **EXAMINATION AND LICENSURE HISTORY** section.

HOSPITAL/INSTITUTION	LOCATION	DATES OF TRAINING	SPECIALTY

If you are employed as a Fellow or House Physician, submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s). If you are currently in training, submit a signed letter from the program director of your training institution on the institution’s letterhead. It must state that you have successfully completed your first year of training and the anticipated date you will complete your training.

EXAMINATION AND LICENSURE HISTORY

15. Have you ever taken any of these examinations administered by the USMLE, FLEX, National Board, or State Boards? Yes No If yes, provide the following information:

EXAM	LOCATION	DATE

16. Have you ever failed a licensing exam? Yes No If yes, explain: _____

17. Have you ever held a medical license issued by another jurisdiction (state, U.S. territory, or District of Columbia)? Yes No If yes, list each jurisdiction where you have ever held a medical license, including training licenses.

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE

DISCLOSURES

If you answer “yes” to Questions 18 - 33 in this section, you must fully explain your answer. It is suggested that you use the [Physician Self-Report](#) form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, you may submit a signed, notarized statement in lieu of or in addition the *Physician Self-Report*. The statement should specify the jurisdiction where the incident occurred, the issues involved and any further information you wish to provide.

18. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes No

Arrange for the Board office to receive State of Delaware and Federal Bureau of Investigation criminal background checks.

19. Have you ever been the subject of an investigation by a licensing authority, medical association, hospital or other healthcare institution? Yes No If yes, provide a copy of any documents in your possession related to the final disposition of the investigation and continue to Question 20. **If no, skip to Question 21.**

20. 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

21. Have you ever been convicted of violating the Medical or Osteopathic Practice Act of another jurisdiction?
Yes No
22. Have you ever engaged in the practice of medicine or osteopathy without a license? Yes No
23. Have you ever been refused a narcotic license or had such license modified, suspended, canceled, or prescribed narcotic drugs unlawfully? Yes No
24. Have you ever willfully violated the confidence of a patient? Yes No
25. Have you ever been convicted of fraud? Yes No
26. Have you ever had a medical or osteopathic license denied, revoked, suspended, or limited or placed under probation? Yes No
27. Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department, or the Drug Enforcement Agency of the Department of Justice or a State's Narcotic Agency in this country or any other country?
Yes No
28. Have you ever had a disciplinary action taken against you by a Medical or Osteopathic Society? Yes No
29. Have your hospital privileges ever changed as a result of a disciplinary action taken by a hospital? Yes No
30. Has a settlement ever been made or a verdict rendered against you in a malpractice action? Yes No
31. Are any charges pending against you or are you under investigation regarding a felony or misdemeanor or unprofessional conduct, or professional misconduct, or malpractice? Yes No
32. Are you now, or have you ever been dependent upon the use of alcohol, stimulants, or habit-forming drugs or been treated or disciplined for their use? Yes No
33. Have you had either a mental or physical illness which interfered with your practice for over a month? Yes No
34. Are you physically and mentally capable of engaging in the practice of medicine according to generally accepted standards, and would you submit to such an examination as the Board may deem necessary to determine your capability? Yes No

DUTY TO REPORT

35. 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

36. 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

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.

37. 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 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. §1731A (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

If this application requires Board review, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **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 license. A complete application is one that includes all required documentation and correct payment.

AFFIDAVIT OF APPLICANT

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 thereunder.

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:** _____

APPLICATIONS THAT ARE INCOMPLETE, UNSIGNED, NOT NOTARIZED OR NOT ACCOMPANIED BY THE REQUIRED PROCESSING FEE WILL BE REJECTED.

VERIFICATION 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.

Printed Full Name of Director of Training Program: _____

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 ____ - _____

NOTARY PUBLIC

State of _____, County of _____

Sworn and subscribed before me this _____ day of _____ 2_____.

SEAL

Notary Public Signature: _____

My Commission expires: _____

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](#) 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.

