



CANNON BUILDING  
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STATE OF DELAWARE  
**DEPARTMENT OF STATE**  
DIVISION OF PROFESSIONAL REGULATION  
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: DPR.DELAWARE.GOV

### APPLICATION TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF DELAWARE

I am applying for licensure as a (check one):

- MD - I received my Medical Education in the United States.
- MD - I received my Medical Education outside the United States.
- DO

Will you use the Federation Credentials Verification Service (FCVS) to provide your Physician Information Profile to the DE Board of Medical Practice? Yes  No

**IDENTIFICATION:**

Name: \_\_\_\_\_  
Last First Middle

Name (if different from above): \_\_\_\_\_  
Last First Middle

Mailing Address: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth (MM/DD/YY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that the disclosure of your social security number on this application is required by 29 Del. C. §8735(m). It may be used to enforce child support obligation pursuant to 13 Del. C. §2216 and for other lawful purposes.

**EDUCATION:**

Medical Education:	School	Location	Dates	Degree
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If you graduated from a foreign medical school, indicate your ECFMG number and complete the Request for Status Report of ECFMG<sup>SM</sup> Certification:

USMLE/ECFMG Identification Number: 0-\_\_\_\_\_

Applicant Name: \_\_\_\_\_

**Post Graduate Training:**

Hospital/Institution	Location	Dates	Specialty
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Area / Field of Specialization	Board eligible?	Board Certified?
_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

1. Have you ever taken any of the following examinations: Yes  No   
 USMLE, FLEX, National Boards or State Boards?

Examination	Date Passed Month/Year
ECFMG (Basic)	_____
ECFMG (Clinical)	_____
ECFMG (English)	_____
FLEX Component 1	_____
Flex Component 2	_____
Pre- 1985 FLEX	_____
USMLE Step 1	_____
USMLE Step 2	_____
USMLE Step 3	_____
NBME Part 1	_____
NBME Part 2	_____
NBME Part 3	_____
NBOME Part 1	_____
NBOME Part 2	_____
NBOME Part 3	_____
SPEX	_____
COMLEX Level 1	_____
COMLEX Level 2	_____
COMLEX Level 3	_____
LMCC	_____
*State Board Examination	_____

\*(Name of state board(s) where examination was taken and passed) \_\_\_\_\_

Applicant Name: \_\_\_\_\_

2. Have you ever had a medical or professional license denied or revoked? Yes  No

List all states where you are **currently licensed**, or **previously licensed**.  
(Please include training license(s):

State or Territory	License #	Effective Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. 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? If yes, submit a certified copy of your criminal history record. Yes  No
4. Have you ever been professionally penalized for a drug related offense? Yes  No
5. Have you ever been professionally penalized or convicted of fraud? Yes  No
6. Have you ever violated the Medical Practice Act of another state? Yes  No
7. Have you ever been disciplined or had formal written action taken by a hospital staff or medical society, or licensing board of another state? (Please note that your response should include any discipline or action taken during your training program including, but not limited to, academic probation.) Yes  No
8. Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way? (Please note that your response should include any limitation, restriction, suspension or revocation of your privileges occurring during your training program including, but not limited to, academic probation.) Yes  No
9. Are any charges or complaints of any type including malpractice claims pending against you at present? Yes  No
10. Have you ever engaged in the practice of medicine without a license? Yes  No
11. Have you ever prescribed narcotic drugs unlawfully? Yes  No
12. Have you ever been convicted of a drug violation? Yes  No

Applicant Name: \_\_\_\_\_

13. Have you ever willfully violated the confidence of a patient? Yes  No
14. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceedings or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, governmental agency, professional organization, or licensing authority? Yes  No
- 14.a. Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a mental, emotional, or nervous disorder or condition) which impairs your judgment or in any way currently affects, or if untreated could affect, your ability to practice medicine in a fully competent and professional manner with safety to patients? If you answered yes, answer questions 14b and 14c. If you answered no, continue on to question 15. Yes  No
- 14.b. Are such current conditions or impairments reduced or ameliorated because of ongoing treatment (with or without medication) or participation in a monitoring program or because of the field of practice, the setting, or the manner in which you have chosen to practice medicine? Yes  No
- 14.c. If you claim to have a mental or physical disability which limits your ability to practice medicine in a fully competent and professional manner with safety to patients, are you willing to accept a conditional or limited license to practice medicine if it is possible to accommodate such disability? Yes  No
15. Have you ever been denied a Drug Enforcement Agency (DEA) registration number or had one revoked or otherwise had your authority to write prescriptions limited or restricted? Yes  No
16. Do you agree to submit to an examination at your own expense should an examination be deemed necessary by the Executive Director of the Board of Medical Practice to determine if your physical and/or mental impairment presents a significant risk to the health or safety of patients or otherwise causes you not to be fully qualified to practice medicine in a competent and professional manner with safety to patients without limitations or accommodations? Yes  No

If you answered **YES** to any questions 2 - 15, or answered **NO** to question 16, fully explain your answer(s) on a separate sheet(s) of paper, sign and swear to its truth before a notary, and attach it to this application. In addition, provide any documentation from the state where this situation occurred, spelling out the issues, and any explanation you wish to provide.

**To assure consideration of your license application at the next Board meeting, 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 six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your license.

I, \_\_\_\_\_, swear that I am the person who executed this application; that the statements contained on this application are true in every respect; that I have not suppressed or withheld information that might affect this application; that I will abide by the laws and the ethical standards of this profession; and that I have read and understand this statement.

I further understand that by filing this application for a Certificate to Practice Medicine and Surgery in the State of Delaware, I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in 24 Delaware Code §1731 or the Rules and Regulations of the Delaware Board of Medical Practice and to determine that I am physically and mentally capable of engaging in the practice of medicine with safety to the public.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, in the year of \_\_\_\_\_

Signature of Notary \_\_\_\_\_

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 Practice 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 Practice 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 Board of Medical Practice will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to (1) keep the information I have provided in this application current until such time as the Board has finally acted on it, and (2) to promptly provide any and all additional information requested by or on behalf of the Board.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, in the year of \_\_\_\_\_

Signature of Notary \_\_\_\_\_

Notary Seal