



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

STATE OF DELAWARE  
DEPARTMENT OF STATE  
DIVISION OF PROFESSIONAL REGULATION  
**BOARD OF PODIATRY**

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

**APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE LICENSE  
INSTRUCTION SHEET**

**Direct Application**

Apply by Direct Application if *either* of these situations applies to you:

- You recently completed your residency year and are not licensed in another state or jurisdiction.
- You are licensed in a state or jurisdiction where the licensure requirements are not substantially similar to those of Delaware and you do not have *at least* five years practice in podiatric medicine. (To find out if the licensure requirements of your state or jurisdiction are substantially similar to Delaware's, see Section 4.2 of the Board's Rules and Regulations.)

If you hold a current license in another state or jurisdiction or you have at least five years of practice, skip to the **Reciprocity** section below.

Submit or have submitted to the Board Office:

- Application for Licensure to Practice Podiatric Medicine*
- Processing fee by check or money order made payable to "State of Delaware" – see *Fee Schedule* at [www.dpr.delaware.gov](http://www.dpr.delaware.gov)
- Official National Practitioners Databank Report – see self-query instructions at [www.npdb-hipdb.com/queryrpt](http://www.npdb-hipdb.com/queryrpt)
- Official transcript sent directly from school to Board office
- Proof of completion of residency
- Exam Score Reports sent directly from exam services
  - National Board of Podiatry Medical Examiners (NBPME) Parts I and II – see [www.nbpme.org](http://www.nbpme.org)
  - PMLexis – see [www.fpmbo.org](http://www.fpmbo.org)
- Verification of licensure sent directly from any state where you hold, *or have ever held*, a license.

**Reciprocity Application**

Apply by Reciprocity if you are *currently* licensed in another State or jurisdiction and *either* of these situations applies to you:

- The state or jurisdiction where you are currently licensed has licensure requirements that are substantially similar to those of Delaware. (To find out if the licensure requirements of your state or jurisdiction are substantially similar to Delaware's, see Section 4.2 of the Board's Rules and Regulations.)
- You have *at least* five years practice in podiatric medicine in the jurisdiction where you are licensed even though the state or jurisdiction does not have licensure requirements that are substantially similar to those of Delaware.

Submit or have submitted to the Board Office:

- Application for Licensure to Practice Podiatric Medicine*
- Processing fee by check or money order made payable to "State of Delaware" – see *Fee Schedule* at [www.dpr.delaware.gov](http://www.dpr.delaware.gov)
- Verification of licensure sent directly from any state where you hold, *or have ever held*, a license.
- Current copies of Podiatry statutes and rules/regulations from the state you are applying through
- If you are not licensed in a state or jurisdiction with with substantially similar requirements, proof of five years of practice:
  - For periods of employment, arrange for your employers to submit Verification of Employment forms.
  - For periods of self-employment, submit tax forms or business licenses.



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**APPLICATION FOR LICENSE TO PRACTICE PODIATRIC MEDICINE LICENSE**

**TYPE OF APPLICATION**

1. I am applying for a license to practice Podiatric Medicine in Delaware by:

- Direct Licensure
- Reciprocity based on my licensure by the state(s) of \_\_\_\_\_

**IDENTIFYING AND CONTACT INFORMATION**

2. Name: \_\_\_\_\_  
Last First Middle Maiden

3. Address: \_\_\_\_\_  
Street  
City State Zip Code

4. Day Phone: \_\_\_\_\_ 5. Email: \_\_\_\_\_

- 6. Have you been issued a U.S. Social Security Number? Yes  No 
  - If yes, enter your SSN: \_\_\_\_\_
  - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

**EDUCATION AND EXAMINATIONS**

7. Enter the following information about the institution where you received your DPM:

Name: \_\_\_\_\_ Date of Degree: \_\_\_\_\_

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

**If you are applying by Direct Application, arrange for your school to send an official transcript directly to the Board Office.**

8. Enter the following information about your residency:

Hospital Name: \_\_\_\_\_

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

Director: \_\_\_\_\_ Attendance Dates: \_\_\_\_\_  
From To

**If you are applying by Direct Application, submit a certificate of completion or equivalent.**

9. Enter the following information about your examinations.

| Examination   | Score | Exam Date |
|---------------|-------|-----------|
| NBPME Part I  |       |           |
| NBPME Part II |       |           |
| PMLEXIS       |       |           |

**If you are applying by Direct Application, request the exam services to send score reports directly to the Board office.**

**LICENSURE AND PRACTICE HISTORY**

10. Enter the following information about all licenses to practice podiatry that you *have ever held*. Attach additional sheet if necessary.

| State | License Number | Issue Date | Status (Current or Expired) |
|-------|----------------|------------|-----------------------------|
|       |                |            |                             |
|       |                |            |                             |
|       |                |            |                             |

**Contact each state listed above and request a written license verification to be sent directly to the Delaware Board of Podiatry.**

11. Enter the following information about the locations and dates of practice. *Include military service.*

| Employer/<br>Practice Name | Address Where Practiced | Nature of Practice | Employment Dates |
|----------------------------|-------------------------|--------------------|------------------|
|                            |                         |                    |                  |
|                            |                         |                    |                  |
|                            |                         |                    |                  |
|                            |                         |                    |                  |

**If you are applying by Reciprocity and you need to document at least five years of practice, arrange for your employer(s) to send Verification of Employment forms directly to the Board office. If you need to document periods of self-employment, submit tax forms or business licenses for the periods.**

12. Have you ever held any other Healthcare license? Yes  No  If yes, enter the following information about the licenses:

| Type of License | State | Has this license been disciplined?                       | If disciplined, explain: |
|-----------------|-------|--|--------------------------|
|                 |       | Yes <input type="checkbox"/> No <input type="checkbox"/> |                          |
|                 |       | Yes <input type="checkbox"/> No <input type="checkbox"/> |                          |
|                 |       | Yes <input type="checkbox"/> No <input type="checkbox"/> |                          |

13. Have you ever been *denied* a license to practice podiatric medicine in any state, territory of the United States or the District of Columbia? Yes  No  If yes, identify the state(s) and reason for denial: \_\_\_\_\_

\_\_\_\_\_

14. Have you ever been the recipient of an administrative penalty regarding your practice of podiatry, including but not limited to fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations, or been a party to a consent agreement containing conditions placed by a Board on your professional conduct and practice, including any voluntary surrender of a license? Yes  No  If yes, provide details including state/ territory, charge, date and cause: \_\_\_\_\_

\_\_\_\_\_

15. Do you have any unresolved complaints pending against you? Yes  No  If yes, provide details: \_\_\_\_\_

16. If you have a DEA or State controlled substance number, has your number ever been denied, revoked, suspended or restricted? Yes  No  If yes, provide details including state/ territory, charge, date and cause: \_\_\_\_\_

\_\_\_\_\_

17. Have you ever had a malpractice judgment or settlement entered against you? Yes  No  If yes, provide details: \_\_\_\_\_

18. Are you presently physically and mentally capable of practicing podiatry? Yes  No

19. Do you have any impairment related to drugs or alcohol, or a finding of mental incompetence by a physician? Yes  No  If yes, provide details: \_\_\_\_\_

\_\_\_\_\_

20. 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, including any offense for which you have received a pardon, in any jurisdiction? Yes  No  If yes, submit a certified copy of your criminal history record.

21. List hospital staff affiliations and duration. Attach additional sheets if needed.

| Hospital Name | <u>Complete</u> Address | Dates of Service |
|---------------|-------------------------|------------------|
|               |                         |                  |
|               |                         |                  |
|               |                         |                  |
|               |                         |                  |

22. Have your hospital privileges ever been suspended, restricted or rescinded based upon a finding of fraud, deception, illegal, incompetent or negligent practice of podiatry? Yes  No  If yes, explain: \_\_\_\_\_

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.

### AFFIDAVIT

*This section to be completed in the presence of a notary public.*

APPLICANT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

STATE OF \_\_\_\_\_ )  
 ) SS  
 COUNTY OF \_\_\_\_\_ )

The above applicant, being sworn, deposes and says that he or she is attesting that all statements contained in his or her application are true and correct in every respect, and that he or she has not suppressed any information that might affect this application.

Sworn to me before me this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_.

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

My commission expires on \_\_\_\_\_.

SEAL