



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 TEMPORARY PODIATRIST LICENSE INSTRUCTION SHEET**

A temporary license may be issued to an out-of-state Podiatrist who will be taking charge of the practice of a Delaware-licensed Podiatrist during the Delaware licensee's temporary illness or absence from Delaware.

If you need licensure for a Delaware residency program, see the instructions for [Podiatrist-In-Training](#) licensure.

### **How to Apply**

Submit:

- Completed, signed and notarized [Application to Practice Podiatric Medicine](#)
- [Processing fee](#) by check or money order made payable to "State of Delaware"
- Verification of licensure from each state in which you currently hold, or have ever held, a license to practice podiatry, sent directly from the State Board to the Board office
- Notarized *Delaware Podiatric Physician's Request Form* (included with application)

Temporary licenses are valid for up to three months from date of issuance.



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### DELAWARE PODIATRIC PHYSICIAN'S REQUEST FORM

The Delaware physician who needs the services of an applicant for a Temporary License must complete and sign this form. The form must be notarized.

1. Name of Delaware-Licensed Podiatrist: \_\_\_\_\_

2. Delaware License Number: \_\_\_\_\_

3. Name of Applicant for Temporary Licensure: \_\_\_\_\_

4. Name of Practice: \_\_\_\_\_

5. Location of Delaware Practice: \_\_\_\_\_

Street

\_\_\_\_\_ DE \_\_\_\_\_  
City State Zip

6. When will the applicant be in charge of this practice? From: \_\_\_\_\_ To: \_\_\_\_\_  
mm/dd/yy mm/dd/yy

7. What is your reason for leaving (e.g., illness, leave of absence)? \_\_\_\_\_

\_\_\_\_\_

### AFFIDAVIT

I request that the Delaware Board of Podiatry grant temporary licensure to the applicant named above for the purpose of taking charge of my practice during my absence.

SIGNATURE OF DELAWARE PODIATRIST: \_\_\_\_\_ Date: \_\_\_\_\_

State of \_\_\_\_\_, County of \_\_\_\_\_

Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_ 2\_\_\_\_.

\_\_\_\_\_  
Notary Public

SEAL

My Commission Expires: \_\_\_\_\_



**LICENSURE AND PRACTICE HISTORY**

9. 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.**

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

Employer/ Practice Name	Address Where Practiced	Nature of Practice	Employment Dates

11. 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"/>	

12. 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: \_\_\_\_\_

\_\_\_\_\_

13. 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: \_\_\_\_\_
14. Do you have any unresolved complaints pending against you? Yes  No  If yes, provide details: \_\_\_\_\_
15. 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: \_\_\_\_\_
16. Have you ever had a malpractice judgment or settlement entered against you? Yes  No  If yes, provide details: \_\_\_\_\_
17. Are you presently physically and mentally capable of practicing podiatry? Yes  No
18. 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: \_\_\_\_\_
19. 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.
20. List hospital staff affiliations and duration. Attach additional sheets if needed.

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

21. 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: \_\_\_\_\_

