



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

STATE OF DELAWARE  
DEPARTMENT OF STATE

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
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DIVISION OF PROFESSIONAL REGULATION

**APPLICATION FOR RESIDENTS, INTERNS, AND FELLOWS APPLYING FOR  
LICENSURE IN DELAWARE**

Return the completed application along with a \$12.00 check or money order made payable to the State of Delaware.

NAME IN FULL: \_\_\_\_\_  
LAST FIRST MI

ADDRESS: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MM/DD/YY

NAME AND LOCATION OF MEDICAL SCHOOL AND DATE OF GRADUATION:  
(Attach a copy of diploma received. If school is located outside the United States, attach a copy of ECFMG Certificate.)

NAME OF MEDICAL SCHOOL

ADDRESS CITY STATE ZIP CODE

NAME AND LOCATION OF INSTITUTION WHERE TRAINING IS TO BE CONDUCTED:

NAME OF INSTITUTION DEPARTMENT PHONE #

ADDRESS CITY STATE ZIP CODE

DATE TRAINING IS TO BEGIN: \_\_\_\_\_

1. Have you ever taken any of these examinations administered by the USMLE, FLEX, National Board, or State Boards?  
( ) Yes ( ) No If yes, provide location:

\_\_\_\_\_ Date \_\_\_\_\_

2. Have you ever failed a licensing exam? ( ) Yes ( ) No If yes, provide details: \_\_\_\_\_

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 convicted of violating the Medical or Osteopathic Practice Act of another state? ( ) Yes ( ) No

5. Have you ever engaged in the practice of medicine or osteopathy without a license? ( ) Yes ( ) No