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

STATE OF DELAWARE
DEPARTMENT OF STATE

DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-450(
FAX: (302) 739-271
WEBSITE: WWW.DPR.DELAWARE.GO

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