

THIS SECTION IS TO BE COMPLETED IN THE PRESENCE OF A NOTARY PUBLIC BY THE PHYSICIAN IN CHARGE OF THE INSTITUTION WHERE THE APPLICANT IS TO BE EMPLOYED. THIS PHYSICIAN WILL ACCEPT RESPONSIBILITY FOR THE PRACTICE OF MEDICINE AND SURGERY OF THIS APPLICANT IN THIS INSTITUTION.

I verify that the above-named applicant will be participating in a training program located at:

_____ beginning _____ and that his/her
NAME OF INSTITUTION MM/DD/YY

credentials have been reviewed and approved. This physician will be participating in this training program under the supervision of a fully licensed physician in the State of Delaware.

Signature/Title of Supervising Physician Date

NOTARY PUBLIC

State of _____, County of _____

Sworn and subscribed before me this _____ day of _____ 20_____.

Notary Public

SEAL

Commission Expires