DELAWARE HEALTH AND SOCIAL SERVICES

Division of Substance Abuse and Mental Health

RETURN FORM TO: 1901 N. DuPont Hwy., Main Administration
New Castle, DE 19720
FAX 302-255-4428

APPLICATION FOR PHYSICIAN MENTAL HEALTH SCREENER

(BOARD CERTIFIED EMERGENCY MEDICINE ONLY)

Application Date: _____ _____ _____
Year Month Day

_____ _____ _____
Applicant's Last Name First Name M.I.

_____ _____ _____ _____
Street Address City State Zip

_____ _____
Daytime Telephone Number Email Address

Educational Level: ☐ MD ☐ DO

I hold a Delaware Medical license: _____
DE Professional License Number

☐ American Board of Emergency Medicine MOC ***Date:*** _____ _____ _____
Year Month Day

Please identify hospital(s) where you practice:

_____ _____
Facility Name Address

_____ _____
Facility Name Address

_____
Applicant's Employer (or self-employed ☐)

_____ _____ _____ _____
Employer's Street Address City State Zip

_____ _____ _____
Applicant's Position Length of Employment (Years and Months)

Describe position's responsibilities:

_____

I declare that the information provided in this application is true and complete to the best of my knowledge. I further attest that I have read and understood the Mental Health Screener training documents.

_____ _____
Applicant's Signature Date