DELAWARE HEALTH AND SOCIAL SERVICES

Division of Substance Abuse and Mental Health

Application for Physician/Psychiatrist Mental Health Screener - Date: / /

Please scan and email to DHSS_DSAMH_MHSCREENER@Delaware.gov

_____ _____

Applicant's Last Name First Name

_____ _____ _____ _____

Street Address City State Zip

_____ _____

Daytime Phone Number Email Address

Education Level: ____MD ____DO

Board Certified Emergency Medicine: ____ YES ____NO

I hold a Delaware Medical License: _____

DE Professional License Number

Please identify hospital(s) where you practice:

_____ _____

Facility Name Address

_____ _____

Facility Name Address

_____

Applicant's Employer (or self-employed)

_____

Employer's Street Address

_____ Length of Employment: _____ _____

Applicant's Position Years Months

Describe position's responsibilities:

_____

I declare that the information provided in this application is true and complete to the best of my knowledge.

_____ _____

Applicant's Signature Date