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STATE OF DELAWARE

BOARD OF EXAMINERS IN OPTOMETRY

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OPTOMETRY INTERNSHIP: STATEMENT OF SUPERVISING DOCTOR

INFORMATION AND INSTRUCTIONS

When an internship ***pre-approved*** by the Delaware Board of Examiners in Optometry is a requirement for Delaware optometry licensure, ***each*** doctor who will be supervising the intern is required to complete, sign and submit a *Statement of Supervising Doctor* form. Note that the statement must be notarized. Mail it *directly* to the Board office at the address above.

The internship period starts the day ***after*** the Board approves it. The period must consist of at least 35 hours per week for at least six months. The intern must be supervised throughout the period by a Board-approved doctor(s).

It is the intern's responsibility to select a doctor to supervise him or her during the internship. Note the following:

- If the supervisor is neither an ophthalmologist nor therapeutically-certified optometrist, the intern must complete 100 additional hours of clinical internship with a therapeutically-certified optometrist, medical doctor or osteopathic physician.
- If the supervisor is a therapeutically-certified optometrist not licensed in Delaware, he or she must be licensed in a jurisdiction where the standards of therapeutic practice are comparable to those in Delaware.

If more than one doctor will be supervising the intern, the Board must approve all of them. Each supervising doctor:

- must supervise the intern "one-on-one"
- can supervise only one intern at a time
- must be on the same premises and immediately available for supervision at all times
- must review the patient evaluations before the patient leaves the office.

These are examples of situations that are ***not*** acceptable direct supervision:

- The supervising doctor has two offices. He/she works in office 1, and the intern works in office 2.
- Three doctors work in the supervising doctor's office. The intern's Board-approved supervisor leaves and assigns a doctor whom the Board has *not* approved to supervise the intern.

This form is also used to report a change in Supervising Doctor in the Service Request *Manage Affiliations*.

INTERN NAME: _____ **APPLICATION ID:** _____

INFORMATION ABOUT SUPERVISING DOCTOR

1. Name: _____

2. Check your license type: ☐ Optometrist ☐ Ophthalmologist ☐ Other Medical Doctor ☐ Osteopathic Physician

   If you are an optometrist, continue with Question 3. Otherwise, skip to Question 4.

3. Are you therapeutically certified in any jurisdiction where you are licensed, including Delaware? Yes ☐ No ☐ **If yes, enter the following information about *each* jurisdiction where you therapeutically certified:**

JURISDICTION	LICENSE NUMBER

4. Enter the following information about the practice where the internship will be served:

   Practice Name: _____

   Practice Address: _____

   _____ _____ _____
   City State Zip

5. Will other optometrists or physicians in your practice supervise the intern at any time? Yes ☐ No ☐ If yes, list the names of ***all*** supervising doctors: _____ _____

   _____ _____ _____

   Each **supervising doctor must complete a *Statement of Supervising Doctor* form.**

INFORMATION ABOUT INTERNSHIP

6. Enter the ***requested*** start and end dates of the internship:

   Start (month/year): _____ End (month/year): _____

   Note: The internship does not begin until the Board approves the dates.

7. Is this internship part of a residency? Yes ☐ No ☐ If yes, enter the start and end dates of the residency:

   Start (month/year): _____ End (month/year): _____

8. What will be the intern's duties? _____

9. What are the internship goals? _____

   _____

10. How many hours per week will the intern work? _____ hours

11. How many hours per week will you ***personally*** supervise the intern? _____ hours

12. Will the intern practice at any location other than the one you entered in Question 4? Yes ☐ No ☐ If yes, enter *each* address where the intern will practice and the number of hours per week he or she will work at each location:

LOCATION	HOURS PER WEEK

13. Does your practice have any other interns? Yes ☐ No ☐

AFFIDAVIT

I certify that the information in this statement is complete and true.

Signature of Supervising Doctor: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My commission expires: _____

If required for an application, mail this form directly to the Board office.
If reporting a change in Supervising Doctor, upload this form with your service request.