



STATE OF IDAHO

BOARD OF MEDICINE

1755 Westgate Dr., Ste 140
Boise, Idaho 83704
(208) 327-7000
FAX (208) 327-7005
E-Mail info@bom.idaho.gov
Website bom.idaho.gov

TO: Idaho Licensure Applicants

FROM: Idaho State Board of Medicine

RE: Idaho Allied Health Licensure

Please note: should your license be issued to you on or before March 30, you will be required to renew by June 30 of that year. If you do not receive a license until after that date, you will not be required to renew until June of the following year.

ja

General Checklist for Athletic Trainer Applicants

** Questions? E-mail jodi.adcock@bom.idaho.gov **

No practice is permitted prior to receipt of a license number. Applicants are advised not to enter irrevocable contracts, purchase or sales agreements, on the assumption that licensure will be granted.

Fee must accompany application. **APPLICATION WILL NOT BE PROCESSED UNLESS ACCOMPANIED BY THE APPROPRIATE FEE.** Amount is indicated on the application. Checks or money orders are to be made payable to the Idaho State Board of Medicine. *Fees are nonrefundable.*

Applications must be on forms provided by the Board and all sections must be complete. Please type or print in ink. Applications must be legible.

Front page of application: If applicant has not applied for registration/licensure in other states, write "Not Applicable" in the appropriate section.

Back page of application:

Chronological account of time – Account for **all** periods of time beginning with the month of graduation to the present time, leaving no gap in time of more than one month. Attach additional pages if necessary.

Questions – Answer all questions 1-8. Provide details, for YES answers, on a separate sheet. Court documents will be required, if applicable.

Photo – Does not need to be a professional photo. A **clear** and **in focus** 3"x4" snapshot taken of the head and shoulders only, with a digital camera, is a good choice. Passport photos are also acceptable.

Notarized – Application **must** be notarized by a notary public and signed by applicant.

Directing Physician Registration (Form 1): Fill in the top section. This form is required from your directing physician(s). Directing physician registration fee needs to accompany this form only if primary directing physician is **NOT** already registered **OR** a chiropractor. Names and addresses must be legible. Chiropractic physicians may need to register with the Bureau of Occupational Licenses, as well as the Board of Medicine.

Certificate of Professional Education (Form 2): Fill in the top section. Be sure to indicate the degree **and** the field of study, the date degree was received, and sign **at the bottom** of the section. Send this form to the school (Registrar or Program Director) where applicant received professional education. The school will then send the form to the Board of Medicine. Official transcripts from the school can be accepted in place of this form.

Certificates of Recommendation (Form 3 & 4): Fill in the top section. Send this form to **two** individuals who have known the applicant professionally for at least **one** year (**no relatives**). Recommendations must be on the form provided or on letterhead addressed to the Board. Names and addresses must be legible.

Verification of Licensure/Registration (Form 6): This form may be duplicated. This is required from **every state** where the applicant has ever held a license/registration and must come directly from the state to the Board. **NOTE:** Most states require a fee for this service, paid in advance. It is strongly suggested that you contact the state(s) prior to sending your request to prevent delays and to determine the best way to send required fees.

Athletic Training Service Plan or Protocol (Form 7): Fill in top section. Form **must** be signed by applicant and directing physician and notarized by a notary public. Once complete, form **must** be returned to the Board of Medicine. **NOTE:** Most physicians have a notary public in their office.

Athletic Training Service Plan or Protocol (Form 8, pgs. 1-4): To be completed by applicant and directing physician (and alt. directing physician, if applicable). Practice site(s) listed should be main practice site with contracted sites listed below it. Travel sites do not need to be listed. **DO NOT** submit Form 8, pgs. 1-4 to the Board of Medicine with your application for licensure.

FAXED and emailed supporting documents can be accepted, but the hard copy is preferred. The applicant's section of the application **cannot** be faxed. FAX# (208) 327-7005.

PLEASE NOTE: Forms received prior to receipt of application and licensure fee will be held in a "Misc. Forms" file for up to one year. After one year, the forms will be thrown away.

IDAHO STATE BOARD OF MEDICINE

P.O. Box 83720 · Boise, ID 83720-0058 · (208) 327-7000
Express Mail: 1755 Westgate Drive, #140 · Boise, ID 83704

APPLICATION - ATHLETIC TRAINER LICENSURE

| FOR USE OF THE BOARD | | | | | |
|----------------------|----------------|-------------------|-------------------|-----------------|----------|
| 1. D/P Registration | 2. Education | 3. Recommendation | 4. Recommendation | 5. Verification | Received |
| NATABOC | 7. Affidavit | 9. Provisional | | | Fee |
| HPDB-HIPDB | SSN Disclosure | | | | Fee |

I hereby apply for:

Athletic Trainer Licensure - Fee \$150

Provisional AT Licensure - Fee \$80

Please note: should your license be issued to you on or before March 30, you will be required to renew by June 30 of that year. If you do not receive a license until after that date, you will not be required to renew until June of the following year.

Make check(s) payable to: IDAHO STATE BOARD OF MEDICINE

| | | | | | |
|--|---------------|--------------------|---------------------------------------|--|----------------------------|
| First Name | | Middle Name | | Last Name | |
| Current Mailing Address (<i>Street, City, State, Zip</i>) | | | | Telephone | |
| Email Address | | | | Social Security No. | |
| Place of Birth (<i>City and State</i>) | | | | Date of Birth (<i>Month/Day/Year</i>) | |
| Height (<i>Ft., In.</i>) | Weight | Hair | Eyes | Complexion | Sex: Male Female |
| NAME AND LOCATION (<i>CITY/STATE</i>) OF SCHOOLS | | | FROM (<i>Month/Day/Year</i>) | TO (<i>Month/Day/Year</i>) | |
| High School | | | | | |
| College/University | | | | | |
| Postgraduate Study | | | | | |

NATABOC Certification Number: _____

| I HAVE APPLIED FOR LICENSURE AND/OR REGISTRATION IN THE FOLLOWING STATES OR COUNTRIES | YEAR | GRANTED | | CURRENT | | NUMBER |
|---|------|---------|----|---------|----|--------|
| | | Yes | No | Yes | No | |
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In chronological order account for all periods of time beginning with the month applicant graduated from college up to the present time **leaving no gap in time of more than one month** (e.g. employed, unemployed, studying for the exam, military service, extended vacation, etc). Attach additional pages if necessary.

| FROM (Month, Year) | TO (Month, Year) | NAME OF INSTITUTION OR PLACE OF PRACTICE AND LOCATION | EMPLOYER |
|-----------------------|---------------------|---|----------|
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| <p style="text-align: center;">NOTE</p> <p>Attach a finished photograph of your head and shoulders only. Photo must have been taken within the last year and be 3"x4" in size.</p> <p>Proof photos, negatives, copies, and instant photos are not acceptable.</p> <p style="text-align: center;">DO NOT STAPLE PHOTO TO APPLICATION</p> | <p style="text-align: center;">CERTIFICATION</p> <p>IF THE ANSWERS TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 5%; text-align: center;">Y</th> <th style="width: 5%; text-align: center;">N</th> <th></th> </tr> </thead> <tbody> <tr> <td>1.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Have you ever failed a licensure exam?</td> </tr> <tr> <td>2.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Have you ever been refused a professional license/registration?</td> </tr> <tr> <td>3.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Have you ever been arrested, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome?</td> </tr> <tr> <td>4.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Have you ever been investigated by any licensing board, agency or professional association in connection with competency, practice act violations, unprofessional conduct or unethical conduct?</td> </tr> <tr> <td>5.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Have you ever been subject to informal or formal proceedings by any licensing board, agency or professional association to revoke, suspend, restrict or limit a professional license/registration?</td> </tr> <tr> <td>6.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Do you currently have or have you had any serious physical or mental condition in the past five years which in any way impairs or limits your ability to practice as an athletic trainer with reasonable skill and safety?</td> </tr> <tr> <td>7.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Do you now or have you ever had employment terminated or restricted, or limitations imposed on such employment or resigned from employment to avoid formal action?</td> </tr> <tr> <td>8.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Do you currently have or have you had problems with the use of alcohol, stimulants habit forming and/or illegal drugs in the past five years which in any way impairs or limits your ability to practice as an athletic trainer with reasonable skill and safety?</td> </tr> </tbody> </table> | | Y | N | | 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever failed a licensure exam? | 2. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been refused a professional license/registration? | 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been arrested, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? | 4. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been investigated by any licensing board, agency or professional association in connection with competency, practice act violations, unprofessional conduct or unethical conduct? | 5. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been subject to informal or formal proceedings by any licensing board, agency or professional association to revoke, suspend, restrict or limit a professional license/registration? | 6. | <input type="checkbox"/> | <input type="checkbox"/> | Do you currently have or have you had any serious physical or mental condition in the past five years which in any way impairs or limits your ability to practice as an athletic trainer with reasonable skill and safety? | 7. | <input type="checkbox"/> | <input type="checkbox"/> | Do you now or have you ever had employment terminated or restricted, or limitations imposed on such employment or resigned from employment to avoid formal action? | 8. | <input type="checkbox"/> | <input type="checkbox"/> | Do you currently have or have you had problems with the use of alcohol, stimulants habit forming and/or illegal drugs in the past five years which in any way impairs or limits your ability to practice as an athletic trainer with reasonable skill and safety? |
|--|---|--------------------------|---|---|--|----|--------------------------|--------------------------|--|----|--------------------------|--------------------------|---|----|--------------------------|--------------------------|---|----|--------------------------|--------------------------|---|----|--------------------------|--------------------------|--|----|--------------------------|--------------------------|--|----|--------------------------|--------------------------|--|----|--------------------------|--------------------------|---|
| | Y | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever failed a licensure exam? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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I, _____, being first fully sworn, depose and say that I am the person herein described and identified; that the answers to the accompanying questions and statements made in this application are true and correct; that I am the lawful holder of the degrees/credentials listed, and that such degrees/certificates were procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, institutions or organizations, my references, personal associates, business associations (past and present) and all government agencies and instrumentalities to release to this licensing Board and information, files or records requested by this Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practicing as an athletic trainer.

I have carefully read the questions in the accompanying application and have answered them completely, without reservation of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information with this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as an athletic trainer in the State of Idaho.

I further declare that the photo of me attached hereto was taken on or about _____, 20____, my age being _____.

State _____ County of _____

Subscribed and Sworn to before me this ___ day of _____, 20____.

(SEAL) Notary Signature _____

My commission expires _____

CERTIFICATE OF RECOMMENDATION

I am applying for licensure to practice as an **athletic trainer** in the State of Idaho. Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, Idaho 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704; Fax: (208) 327-7005. (Note: Two certificates of recommendation are required. Please duplicate this form.) Recommendations should be from persons who have known the applicant professionally for at least one year.

Applicant's Name: _____

Address: _____

Do you request that this information be confidential? ___ Yes ___ No

TO: Idaho State Board of Medicine:

I have known _____ for _____ years,
from _____ to _____ while he/she was studying
or practicing as an athletic trainer. To the best of my knowledge he/she
is of good moral and professional character and ethics.

Additional Comments:

Signature _____

Printed Name _____

Date _____

Address _____

Profession _____

CERTIFICATE OF RECOMMENDATION

I am applying for licensure to practice as an **athletic trainer** in the State of Idaho. Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, Idaho 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704; Fax: (208) 327-7005. (Note: Two certificates of recommendation are required. Please duplicate this form.) Recommendations should be from persons who have known the applicant professionally for at least one year.

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Additional Comments:

Signature _____

Printed Name _____

Date _____

Address _____

Profession _____

VERIFICATION OF LICENSURE/REGISTRATION

Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704; Fax: (208) 327-7005. (If additional forms are needed, this form may be duplicated.)

I am applying for licensure to practice as an athletic trainer in the State of Idaho. The Idaho State Board of Medicine requires verification of registration/licensure from each state wherein I hold or have held registration/licensure. This is your authority to release any information in your files favorable or otherwise, directly to the Idaho State Board of Medicine, at the address indicated above.

Applicant's Name: _____

Applicant's Address: _____

My Registration/License No. is: _____

State of: _____ Registration/License No.: _____ Issue Date: _____

Name of Registrant/Licensee: _____

Issued by: _____ Endorsement/Reciprocity with: _____

_____ Examination (NATA)

Status: Current Yes ___ No ___ Expiration Date _____

Do you have any record of disciplinary or legal action that should be considered with this athletic trainer's application? Yes ___ No ___

Comments:

Signature

Title

(Board Seal)

Date

State Board

Verification - Not an Endorsement

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

Athletic Trainer's Name: _____

Directing Physician's Name: _____

Alternate Directing Physician's Name(s): _____

Practice Site(s): _____

Type of Practice: _____

AFFIDAVIT

I, being first duly sworn, declare under penalty of perjury as follows: (Please check the statement that applies)

I will be practicing as an athletic trainer in Idaho and meet the requirements listed below OR

Prior to any practice as an athletic trainer in Idaho, I will meet the requirements listed below.

I will be practicing as an athletic trainer in Idaho and prior to any practice in Idaho, I will meet the requirements listed below.

I have completed the "Athletic Training Service Plan or Protocol" forms with my directing physician and have reviewed the agreement with my alternate directing physician.

A copy of the agreement is on file at each of my practice sites and is available to the Board upon request.

The agreement defines the working relationship and direction between my directing physician and me and includes: a list of the specific activities that will be performed by the athletic trainer; specific locations and facilities in which the athletic trainer will function; the methods to be used to insure responsible direction and control of the activities of the athletic trainer, which shall provide for: and on-site visit at least bi-annually and a periodic review of a representative sample of records. This review shall also include an evaluation of the quality of athletic training services being provided, the availability of the directing physician to the athletic trainer in person or by telephone, and procedures for providing backup for the athletic trainer in emergency situations, and procedures for addressing situations outside the scope of practice of the athletic trainer.

The written criteria were jointly developed by my directing physician, my alternate directing physician, and me. The agreement permits me to work under the direction of my directing physician(s).

Signature of Athletic Trainer Applicant: _____

Date of Signature: _____

Signature of Directing Physician: _____

Date of Signature: _____

Subscribed and sworn to before me this _____ day

of _____, 20____

(SEAL)

Signature _____

Notary Public for _____

Commission Expires _____

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

An Athletic Training Service Plan or Protocol is to be maintained at each practice site and available to the Board upon request. The Athletic Training Service Plan or Protocol is a written document mutually agreed upon and signed and dated the athletic trainer and directing physician that defines the working relationship and direction between the directing physician and the athletic trainer as specified by Board rule. The Board of Medicine may review the written Athletic Training Service Plan or Protocol, job descriptions, policy statements, or other documents that define the responsibilities of the athletic trainer in the practice setting, and may require such changes as needed to achieve compliance with these rules, and to safeguard the public.

DO NOT SUBMIT YOUR ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL (FORM 8, PAGES 1-4) TO THE BOARD WITH YOUR APPLICATION FOR LICENSURE.

The following must be legible. Use additional sheets if necessary.

Athletic Trainer's Name: _____

Directing Physician Name: _____

Alternate Directing Physician(s) Name(s): _____

PRACTICE SITE(S):

1. Name of Facility/ School/Organization: _____

Address: _____

2. Name of Facility/ School/Organization: _____

Address: _____

3. Name of Facility/ School/Organization: _____

Address: _____

4. Name of Facility/ School/Organization: _____

Address: _____

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

Each licensed athletic trainer shall maintain a current copy of an Athletic Training Service Plan or Protocol between the athletic trainer and each of his or her directing physicians. This agreement shall **NOT** be sent to the Board, but must be maintained on file at each location in which the athletic trainer is practicing. This agreement shall be made immediately available to the Board upon request and shall include:

ACTIVITIES

A listing of the general activities that will be performed by the athletic trainer. Check all that apply. (If checked, please list below anything in that section that is NOT part of your general activities.)

Prevention of athletic injuries by designing and implementing physical conditioning programs, performing preparticipation screenings, fitting protective equipment, designing and constructing protective products and continuously monitoring changes in the environment.

Comments: _____

Recognition and evaluation of athletic injuries by obtaining a history of the injury, individual inspection of the injured body part and associated structures and palpation of bony landmarks and soft tissue structures. Immediate care of athletic injuries may require initiation of cardiopulmonary resuscitation, administration of basic or advanced first aid, removal of athletic equipment, immobilization and transportation of the injured athlete. The athletic trainer will determine if the athlete may return to participation or, if the injury requires further definitive care, the athletic trainer will refer the injured athlete to the appropriate physician.

Comments: _____

Rehabilitation and reconditioning of athletic injuries by administering therapeutic exercise and physical modalities including cryotherapy, thermotherapy, and intermittent compression or mechanical devices. (Please list mechanical devices used.)

Comments: _____

Athletic training services administration includes implementing athletic training service plans or protocols, writing organizational policies and procedures, complying with governmental and institutional standards and maintaining records to document services rendered.

Comments: _____

Education of athletes to facilitate physical conditioning and reconditioning by designing and implementing appropriate programs to minimize the risk of injury.

Comments: _____

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

EMERGENCY PROCEDURES

Procedures for providing the availability of the directing physician to the athletic trainer in person or by telephone and procedures for providing direction to the athletic trainer in emergency situations.

Please describe below how this will be accomplished at practice site(s):

ADDRESSING SITUATIONS OUTSIDE THE SCOPE OF PRACTICE

Procedures for addressing situations outside the scope of practice of the athletic trainer (e.g. substance abuse, eating disorders).

Please describe below how this will be accomplished at practice site(s):

Signatures:

Athletic Trainer _____ Date: _____

Directing Physician _____ Date: _____

Alternate Directing Physician _____ Date: _____

**STATEMENT REGARDING DISCLOSURE OF
SOCIAL SECURITY NUMBERS**

The Idaho State Board of Medicine (hereinafter Board) requires disclosure of social security numbers on all applications for initial licensure and renewal. Disclosure of social security numbers is mandatory for purposes of enforcing child support orders under Idaho Code § 7-1416 and compliance with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank, as required by 45 CFR §§ 61.1 *et seq.* If this Board is required to make a report about an applicant or licensee to the Idaho Department of Health and Welfare or either of these data banks, the report must contain that individual's social security number. Failure to provide a social security number for these mandatory purposes will result in denial of an application for initial licensure or renewal.

An applicant for initial licensure or renewal may also voluntarily disclose his or her social security number for release to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation, such as the Federation of State Medical Boards' Physician Data Center. The Center compiles information about individual applicants and licensees and transmits that information to other licensing boards in order to coordinate licensure and disciplinary activities between the individual States. Such disclosure is for identification purposes only. Social security numbers will not be released for any other purpose not provided for or allowed by law.

I do _____ do not _____ give the Idaho State Board of Medicine permission to disclose my social security number to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation.

DATED This _____ day of _____, 20____.

Applicant's signature

Applicant's printed name

Authorization for Release of Information

This form is to be completed by the applicant with the name(s) of any other individual(s) or entity(s), besides the applicant, that the applicant would allow this Board to discuss the status of the pending application, i.e. spouse, staff member, etc, and returned with the application. **Without this completed form, the Board may only discuss the pending status with the applicant.**

I will be the only individual inquiring about the status of my application. If you are not authorizing the release of information to a third party, you will **not** need to have this form notarized, just sign and date below.

I authorize the following individuals to inquire about the status of my application (see below):

First Name Last Name Relationship to Applicant

Name of Entity (University, Hospital, etc)

Telephone Number Email Address

First Name Last Name Relationship to Applicant

Name of Entity (University, Hospital, etc)

Telephone Number Email Address

I hereby authorize and direct the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys at any time to release information regarding my filed application for an Idaho license and/or permit with the Idaho State Board of Medicine to the individuals named above.

I further authorize the Idaho State Board of Medicine, employees, agents, officers, representatives, and attorneys who have such information to consult with or discuss such information with any of the individuals named above.

Upon my knowledge and with legal consultation, I understand the nature of this Authorization for Release of Information with regard to my filed application for an Idaho license and/or permit with the Idaho State Board of Medicine.

I, and my heirs, do hereby release the Idaho State Board of Medicine, Committee on Professional Discipline of the Idaho State Board of Medicine, and its members, employees, agents, officers, representatives, and attorneys, from all liability and all claims of any nature whatsoever pertinent to the information released.

Name of Applicant: _____
(First, Middle, Last)

Signature: _____ Date: _____

State of: _____ :SS

County of: _____

On this ____ day of _____, 20____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

I WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

Notary Public for _____

Residing at: _____

My commission expires: _____



STATE OF IDAHO

BOARD OF MEDICINE

1755 Westgate Dr., Ste 140
Boise, Idaho 83704
(208) 327-7000
FAX (208) 327-7005
E-Mail info@bom.idaho.gov
Website bom.idaho.gov

Credit Card Transmittal Form

~Print Legibly~

Order Information: _____
(Description of what & who payment is for)

Name as it appears on card: _____

Billing Address: _____

City _____ State _____ Postal Code _____

Telephone Number: _____

Card Number: _____ - _____ - _____ - _____

Type of Card MasterCard Visa

Expiration (mm/yy) _____ Authorized Charge Amount: _____

If you would like to receive a receipt of this transaction, provide your email address below.

Email Address: _____

All fields (except email) are required in order to process payment/order.