

CHANGE NOTIFICATION FORM

Athletic Trainer Name _____

Mailing Address _____

Email Address _____

Is this a mailing address change? Yes No **AT License Number** _____

Idaho code (IDAPA 22.01.10.013) requires each licensed athletic trainer to notify the Board within **thirty (30) days** of any change in the status of their directing physician. Failure to do so is grounds for disciplinary action.

Please complete all sections of all forms, sign and return to the Board with all supporting documentation to the Board **prior** to practice.

I am changing adding practice sites and directing physicians.

My new primary directing physician is: _____

My new alternate directing physician(s) is/are: _____

My new practice location is: _____

Other Changes:

The practice site listed above will be on a part time basis in addition to my primary practice.

I am deleting the following directing physician(s) or practice site(s): _____

I hereby notify the Idaho State Board of Medicine of the following changes in my direction and/or practice. Attached to this form are the Service Plan or Protocol forms and Directing Physician Registration form with the fee, if applicable. A copy of form 8, Pages 1-4, will be kept on file at each of my practice locations and the address of the primary directing physician.

Submitted by: _____
(Please type or print name)

Signature: _____

Effective date: _____

General Checklist for Athletic Trainer Practice Change Forms

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

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.

Athletic Training Service Plan or Protocol (Form 7): Fill in top section. Form **must** be signed by licensee and directing physician(s) 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 licensee 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. You **DO NOT** need to submit Form 8, pgs. 1-4 to the Board of Medicine unless they are requested.

FAXED or emailed documents can be accepted. FAX# (208) 327-7005.

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: _____