IDAHO STATE BOARD OF MEDICINE COVID-19 RESPONSE

Temporary License Instructions during COVID-10

What is a temporary license?

The Idaho State Board of Medicine has provided for the issuance of a no fee temporary license to qualified applicants during this Public Health Emergency due to COVID-19, as declared by the Governor of Idaho, March 13, 2020. A temporary license is valid for 120 days from date of issue.

What are the criteria for a temporary license?

In brief, simple language, in order to qualify for a temporary license, you must:

1. Be a retired or inactive physician, physician assistant or respiratory therapist.
2. Actively practiced in the past 5 years in Idaho or another US state or Canada and had no disciplinary action, suspension, or restrictions at the time of retirement or inactivity

What are the steps to receive a temporary licensure?

1. Complete the two (2) page temporary application form.
2. Fax or email the completed application form to the Idaho State Board of Medicine.
3. Complete Authorization for Release of Information for Temporary License Application if you need a third party informed of the status of a pending application.
4. Upon receipt and approval of the completed application you will receive an email with your temporary license number and memo regarding the Telehealth Act.

NOTE: Contact information is on the top of the application. Incomplete applications or missing information will delay the issue of a temporary license.

Please review the Idaho State Board of Medicine's Proclamation created for Idaho's public health emergency,

IDAHO STATE BOARD OF MEDICINE COVID-19 RESPONSE
TEMPORARY LICENSE APPLICATION

PO Box 83720 · Boise, ID 83720-0058
345 W. Bobwhite Court, Suite 150 · Boise, ID 83706
PHONE: (208) 327-7000 · FAX: (208) 327-7005
EMAIL: licensing@bom.idaho.gov

FOR USE OF THE BOARD			
License Verification	NPDB		Received in office
Approved	Issue Date	Temp Lic #	Received by staff

I hereby apply for a temporary license (valid up to 120 days) to practice as a medical professional in Idaho. *(There will be no fee for this temporary license)*

Check one box:

☐ **MD** ☐ **DO** ☐ **PA** ☐ **RT**

Please submit the following in support of this application:

First Name	**Middle Name**	**Last Name**
Current Mailing Address *(Street)*		**Mobile Telephone**
(City, State, Zip)		**Social Security No.**
Email Address		**Date of Birth** (*Month/Day/Year*)
Specialty *(MD, DO, and PA only)*		**Sex:** Male ☐ Female ☐

Have you ever applied for an Idaho Medical License: NO ☐ YES ☐ If YES, please provide date:

I HAVE HELD LICENSURE IN THE FOLLOWING STATES	**Year**	**CURRENT**		**NUMBER**
		Yes	**No**	

In chronological order, account for work history for the last **five** years to the present leaving a gap of no more than one month. Attach additional pages if necessary.

FROM (Month/Year)	TO (Month/Year)	TYPE OF PRACTICE	NAME OF INSTITUTION/PLACE OF PRACTICE AND LOCATION

CERTIFICATION

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.

YES	NO	
☐	☐	1. Have you ever had an application for a professional license denied or refused?
☐	☐	2. Are you currently under investigation by any licensing board, hospital, healthcare organization, agency or professional association in connection with medical incompetency, practice act violations, unprofessional conduct or unethical conduct?
☐	☐	3. Have you ever been required to surrender a state and/or federal narcotic registration certificate?
☐	☐	4. Have you ever been arrested, cited, charged with or convicted of a felony or misdemeanor other than minor traffic violations **regardless of the outcome**? This includes withheld judgements and matters that have been expunged.
☐	☐	5. Are you currently suffering from any physical or mental condition for which you are not being appropriately treated that impairs your judgement or that would otherwise adversely affect your ability to practice your medical profession with reasonable skill and safety?

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/credentials were pro cured 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 associates (past and present) and all government agencies and instrumentalities to release to this licensing Board any 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 practice of medicine and surgery during the time that I am a licentiate of this Board.

I have carefully read the questions in the accompanying application and have answered them completely, without reservation of any kind, and I 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 medicine and surgery in the State of Idaho.

Applicant Printed Name ____

Applicant Signature ____

IDAHO STATE BOARD OF MEDICINE COVID-19 RESPONSE
Authorization for Release of Information for Temporary License Application

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.

☐ 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 a temporary Idaho license 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 a temporary Idaho license 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: ______________