

IDAHO STATE BOARD OF MEDICINE

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

I hereby apply for registration as a(n):

MEDICAL RESIDENT – Fee \$20**MEDICAL STUDENT/EXTERNS – Fee \$10***(Please type or print)*

First Name		Middle Name		Last Name	
Public Address (Street)			(City, State, Zip)		*Social Security No.
*Confidential Address (Street)			(City, State, Zip)		
*Email Address			*Date of Birth (Month/ Day/Year)		
*Telephone			Sex: Male Female		
EDUCATION		ADDRESS		CITY/STATE/ZIP	
MEDICAL SCHOOL				DATES	
				TO	
POSTGRADUATE				DATES	
				TO	
				DEGREE	
				MD or DO (circle one)	

Include with this form:

- 1) Copy of birth certificate or passport.
- 2) Name, address, and description of the course of study in Idaho. Please provide on a separate sheet.
- 3) For R-1 residents and interns prescription authority for Schedule III-V medications may be requested if such is integral to the training program. A statement to this effect from the program director is necessary in such cases.
- 4) Summary information regarding the following: Criminal charges or conviction (regardless of the outcome), medical disciplinary actions, malpractice actions, if any. Please provide details on a separate sheet and court documents.

Registration requested to begin _____.

Please Note: Registration will expire **June 30** of the following year. Registration can be renewed annually.Applicant's Signature
X

Date

Statement of primary & alternate supervising physician:

Applicant will work under my personal supervision during the time period stated, and I assume responsibility for the applicant's work.

Name of Primary Supervising Physician (Please Print)		Name of Alternate Supervising Physician (Please Print)	
Signature of Supervising Physician X		Signature of Alternate Supervising Physician X	
Name of Practice Site		Name of Practice Site	
Address	Date	Address	Date