

## 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):

**WWAMI MEDICAL RESIDENT**

**WWAMI MEDICAL STUDENT/EXTERN**

*(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: <input type="checkbox"/> Male <input type="checkbox"/> Female	

EDUCATION	NAME	LOCATION	DATES	DEGREE
MEDICAL SCHOOL			TO	<b>MD or DO</b> <i>(circle one)</i>
POSTGRADUATE			TO	

**Include with this form:**

- 1) Copy of birth certificate or passport.
- 2) 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.
- 3) 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 _____  <p style="text-align: center;"><b><u>Please Note:</u></b> Registration will expire <b>June 30</b> of the following year. Registration can be renewed annually.</p>	
Applicant's Signature  X	Date
<b>Statement of primary supervising physician:</b> Applicant will work under my personal supervision during the time period stated above, and I assume responsibility for the applicant's work.	
Name of Primary Supervising Physician <i>(Please type or print)</i>	Date
Signature of Supervising Physician <div style="text-align: right;">X</div>	Date

\*Confidential-for Board Staff use only.