

**STATE OF IDAHO  
PATIENT FREEDOM OF INFORMATION ACT**

**PROVIDER INITIAL REPORT FORM**

Idaho Code §54-4603 requires that every applicant for licensure or registration and every currently licensed or registered Chiropractor, Dentist, Nurse Practitioner, Certified Registered Nurse Anesthetist, Optometrist, Physician, Surgeon, Physicians' Assistant, Physical Therapist, Podiatrist, and Psychologist furnish the following information prior to the issuance or renewal of a license or registration: (Use additional pages, clearly labeled by section letter, if more space is necessary.)

**LICENSEE -**

(license number) M - \_\_\_\_\_ O - \_\_\_\_\_  
(name) \_\_\_\_\_  
(public mailing address) \_\_\_\_\_  
(city, state, zip) \_\_\_\_\_  
(date of birth m/d/yyyy) \_\_\_\_\_

**A. EDUCATION -**

**Medical School** \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Graduation date \_\_\_\_\_

**Internship** \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Completion date \_\_\_\_\_

**Residency** \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Completion date \_\_\_\_\_

**Fellowships, etc** \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Attendance dates \_\_\_\_\_

**B. SPECIALTY CERTIFICATIONS** - Specialty certifications that are recognized by the American Board of Medical Specialties, e.g. Family Practice, Psychiatry  
\_\_\_\_\_

**C. SPECIAL POSITIONS** - Appointments to faculty of any medical/professional school and indication whether you have had a responsibility for graduate education within the most recent 10 years (optional)

Position \_\_\_\_\_ School \_\_\_\_\_  
\_\_\_\_\_

**D. LOCATION & PRACTICE HISTORY** - Location & type of practice for the most recent 10 years, and the current location of your primary practice setting. If more than 1 setting, include the approximate percentage of time spent at each location.

Current facility name \_\_\_\_\_ % \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Type of practice \_\_\_\_\_  
Beginning & ending date \_\_\_\_\_ - Present

Most recent past facility name \_\_\_\_\_ % \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Type of practice \_\_\_\_\_  
Beginning & ending date \_\_\_\_\_ - \_\_\_\_\_

Past facility name \_\_\_\_\_ % \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Type of practice \_\_\_\_\_  
Beginning & ending date \_\_\_\_\_ - \_\_\_\_\_

Some of my practice was locum tenens during part of the past 10 years  
 Yes  No Years \_\_\_\_\_ - \_\_\_\_\_

**E. PRIMARY ADMITTING HOSPITAL** - The hospital that serves as your primary admitting facility and at which you have **ACTIVE** clinical privileges in good standing  
Facility name \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_

**F. MEDICAID / MEDICARE** -  
Do you participate in medicaid?  Yes  No Ever been barred from participation?  Yes  No  
Do you participate in medicare?  Yes  No Ever been barred from participation?  Yes  No

**G. TRANSLATING SERVICES** – Do you provide any translating services? (optional)  
What language \_\_\_\_\_

**H. CRIMINAL HISTORY** - Description of any criminal convictions for felonies (or other crimes of moral turpitude) within the most recent 10 years. For purposes of this subsection, you shall be deemed convicted of a crime if you pled guilty or were found or adjudged guilty by a court of competent jurisdiction  
List conviction description \_\_\_\_\_  
Charge \_\_\_\_\_ Date \_\_\_\_\_

**I. BOARD DISCIPLINARY HISTORY** - Description of any final disciplinary actions, including but not limited to revocation or suspension of license, taken against you by ANY board from ANY state within the most recent 10 years  
List disciplinary action \_\_\_\_\_ State \_\_\_\_\_  
Charge \_\_\_\_\_ Date \_\_\_\_\_

**J. OTHER DISCIPLINARY HISTORY** - Description of any revocation or involuntary restriction of your hospital privileges, or a reduction in your credentialing for more than 180 days, from ANY state, for reasons related to your competence or character, after procedural due process has been afforded; or your resignation from or non-renewal of a medical staff membership, or the restriction of your privileges at a hospital taken in lieu of or in settlement of a pending disciplinary case related to your competence or character in that hospital, within the most recent 10 years  
List privilege sanction \_\_\_\_\_ Date \_\_\_\_\_  
Hospital \_\_\_\_\_ Reason \_\_\_\_\_

**K. PROFESSIONAL LIABILITY INSURANCE** -  
Do you carry professional liability insurance?  Yes  No  
Have you ever been denied professional liability insurance?  Yes  No

**L. MALPRACTICE HISTORY** - Disclose all malpractice court judgments and all malpractice arbitration awards against you in which a payment was awarded to a complaining party during the most recent 10 years. Disclosure of pending malpractice claims is not required.  
List *judgment* \_\_\_\_\_ Award \$ \_\_\_\_\_ Date \_\_\_\_\_

**M. SETTLEMENT HISTORY** - Disclose all settlements of professional malpractice claims against you within the most recent 5 years of continuous practice;

- (i) You need only disclose malpractice settlements if there have been 5 or more settlements in the most recent 5 years of continuous practice, of \$50,000, or more, per settlement, or if there have been more than 10 settlements within the most recent 5 years of continuous practice of any dollar amount;
- (ii) Settlements that result solely in an adjustment to the fee charged for your services shall not be disclosed pursuant to this chapter;
- (iii) Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of a provider. A payment in settlement of a malpractice action or claim should not be construed as creating presumption that malpractice has occurred. Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation.";
- (iv) Nothing herein shall be construed to limit or prevent the board from providing further explanatory information regarding settlements;

List *settlement* \_\_\_\_\_ Award \$ \_\_\_\_\_ Date \_\_\_\_\_

**N. PROFESSIONAL OWNERSHIP** - Disclose the percentage of ownership interest you have in other health facilities, laboratories, equipment or therapy, except for ownership interest in the primary practice business, to which your patients are, have been, or may be referred.

Facility name \_\_\_\_\_ Percentage \_\_\_\_\_

I hereby swear (or affirm) under oath that the information provided above is true and correct to the best of my knowledge. I understand that neither the Board that issues my license/registration nor the entity providing the profile shall be held liable for the correctness or completeness of the information contained in my profile. I further understand that any release of the information provided by me will include a disclaimer statement attesting to the self-reporting nature of the program, and that the information has not been verified by the board or the reporting entity. I further understand that my failure to provide a full and truthful disclosure of information to the board within the time specified, may result in a fine of up to fifty dollars (\$50.00) for each day that I am not in compliance with the requirement to report and that the board may take any other disciplinary action it deems appropriate, except the board may not revoke, suspend, refuse to issue or refuse to renew a license or registration solely because I failed to comply with the requirement to report.

\_\_\_\_\_  
Licensee signature

State of \_\_\_\_\_, County of \_\_\_\_\_, ss.

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

(seal)

\_\_\_\_\_  
Notary Public official signature

Residing at \_\_\_\_\_

My commission expires \_\_\_\_\_

**Return Profile Form to:**

**IDACARE  
PO Box 83720  
Boise, ID 83720-0058**