



# STATE OF IDAHO

## BOARD OF MEDICINE

1755 Westgate Dr., Ste 140  
Boise, Idaho 83704  
(208) 327-7000  
FAX (208) 327-7005  
E-Mail [info@bom.idaho.gov](mailto:info@bom.idaho.gov)  
Website [bom.idaho.gov](http://bom.idaho.gov)

TO: Idaho Licensure Applicants  
FROM: Idaho State Board of Medicine  
RE: Idaho Licensure

Please note that all physician assistant licenses expire June 30<sup>th</sup>. An initial license, when approved, will be issued for at least one year. Applicants will be assessed a prorated renewal fee to bring their license expiration date into concurrence with the next scheduled expiration date. **Applicants will be required to pay this fee prior to receiving initial license.**

Please contact the Board of Medicine office at 208-327-7000 if you have any questions.

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## GENERAL CHECKLIST FOR PHYSICIAN ASSISTANT APPLICANTS

**Fee(s)** must accompany application. **APPLICATION WILL NOT BE PROCESSED UNLESS ACCOMPANIED BY THE APPROPRIATE FEE(S).** See your application regarding the amount to be sent with your application.

**Applications** must be on forms provided by the Board and all sections must be complete. Please type or print in ink. Applications **must** be legible.

**Front page of application:** If applicant has not applied for registration/licensure in other states, write “Not Applicable” in the appropriate section.

**Back page of application:**

**Chronological account of time** – Account for **all** periods of time beginning with the month of graduation to the present time, leaving no gap in time of more than one month. Attach additional pages if necessary.

**Questions** – Answer all questions 1-10. Provide details, if necessary, on a separate sheet. Court documents may be required.

**Photo** – Does not need to be a professional photo. A **clear** and **in focus** 3”x4” snapshot taken of the head and shoulders only, with a digital camera, is a good choice. Passport photos are also acceptable.

**Notarized** – Application **must** be notarized by a notary public and signed by applicant.

**Finger Print Card** – Take to local law enforcement office and return with Fingerprint Statement. **Per the requirements of the FBI, fingerprint cards can only be mailed to and returned from Applicant's personal address.** ?

**Form 1, Supervising Physician Form:** The Supervising Physician may designate at least one alternate supervising physician to oversee the physician assistant during the supervising physician’s temporary absence. No practice is permitted if the primary supervising physician is not available and an alternate has not been designated. **All** physicians supervising need to complete this form. ?

**Form 2, Certificate of Professional Education:** Fill in the top section. Be sure to sign **at the bottom**. Send this form to the institution where applicant completed the baccalaureate degree. The program will then return the completed form with transcripts to the Board of Medicine. You will need to contact your school for the necessary fee requirements for transcripts. Graduates from PA baccalaureate or masters programs are **not** required to complete this. ?

**Form 3, Physician Assistant Training Program:** Fill in the top section. Be sure to sign **at the bottom**. Send this form to the Physician Assistant training program (Registrar/Program Director) where applicant completed training. The program will then return the completed form **and** transcripts to the Board of Medicine. Transcripts **must** document 30 hours of pharmacology courses. If the transcripts do not state pharmacology the applicant **must** request the approved PA program to send such supporting documentation directly to the Board. You will need to contact your school for the necessary fee requirements for transcripts.

**Form 4/5, Certificate of Recommendation:** Fill in the top section. Recommendations should be from persons who have known the applicant professionally for at least one year. Two certificates of recommendation are required; you will need to duplicate this form. The recommending person **must** fill out and return this form to the Board.

**Form 6, Delegation of Services Agreement (DOS):** Fill in the top section. The DOS is a written document mutually agreed upon and signed and dated by the physician assistant and supervising physician that lists the physician assistant’s training, experience and education and defines the working relationship and delegation of duties between the supervising physician and physician assistant as specified by Board Rule. A DOS is to be maintained at each practice site, at the address of record of the supervising physician and the Board of Medicine. Be specific on filling these forms out, this is your job description.

**Form 7, Physician Assistant Application for Prescription Privileges:** This form must be notarized and filled out by the physician assistant and supervising physician. Please note the frequency must be filled out on this form, ex: weekly, monthly, or bi-weekly.

**Form 9, Verification of Registration/Licensure:** This form must be forwarded by the applicant to all states in which the applicant holds or has held licensure/registration. **Most states charge a fee.**

**FAXED** and emailed supporting documents can be accepted, but the hard copy is preferred. **The applicant’s section of the application cannot be faxed.** FAX# (208) 327-7005.

**PLEASE NOTE:** Forms received prior to receipt of application and licensure fee will be held in a “Misc. Forms” file for up to one year. After one year, the forms will be thrown away.

No practice is permitted prior to issuance of a license number.

Applicants are advised not to enter irrevocable contracts, purchase or sales agreements, on the assumption that permit/licensure will be granted.

**IDAHO STATE BOARD OF MEDICINE**

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

**APPLICATION - PHYSICIAN ASSISTANT LICENSE**

FOR USE OF THE BOARD						
1. Supervising Phys	Practice Affidavit	2. Education	Transcripts	3. PA Training	PA Transcripts	Received
4.Recommendation	5.Recommendation	6. DOS	7. Rx Priv	8. NCCPA	9. Verification	
SSN Disclosure	NPDB	FP Statement	FP Card	FP Report		

I hereby apply for:

- Physician Assistant Licensure** - Fee \$200
- Graduate Physician Assistant Licensure** - Fee \$200

PLEASE NOTE: Fees are nonrefundable

? **Make check payable to: IDAHO STATE BOARD OF MEDICINE**

<b>First Name</b>		<b>Middle Name</b>		<b>Last Name</b>	
<b>Current Mailing Address (Street)</b>				<b>Telephone</b>	
(City, State, Zip Code)				<b>Social Security No.</b>	
<b>Email Address</b>				<b>Date of Birth (Month/Day/Year)</b>	
<b>Height (Ft., In.)</b>	<b>Weight</b>	<b>Hair</b>	<b>Eyes</b>	<b>Complexion</b>	<b>Sex:</b> Male Female

NAME AND LOCATION (CITY/STATE) OF SCHOOLS	FROM (Month/Day/Year)	TO (Month/Day/Year)
<b>College/University</b>		
<b>Physician Assistant Program</b>		
<b>Postgraduate Study</b>		

I HAVE APPLIED FOR LICENSURE IN THE FOLLOWING STATES OR COUNTRIES	YEAR	GRANTED		CURRENT		NUMBER
		Yes	No	Yes	No	
?						

In chronological order, account for all periods of time from completion of professional school to present **leaving no gap in time of more than one month.** Include post-graduate study, private practice, military service, etc. Attach additional pages if necessary.

FROM (Month/Day/Year)	TO (Month/Day/Year)	NAME OF INSTITUTION OR PLACE OF PRACTICE AND LOCATION	EMPLOYER

**NOTE** 

Attach a finished photograph of your head and shoulders only. Photo must have been taken within the last year and be 2"x2" passport to 3"x4" in size.

**Proof photos, digitals, negatives, copies, and instant photos are not acceptable.**

**DO NOT STAPLE PHOTO TO APPLICATION**

- 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 failed a licensing examination for a professional license/registration?
  2. Have you ever had an application for a professional license/registration denied?
  3. Have you ever been investigated by any licensing board, agency or professional association in connection with competency, practice act violations, unprofessional conduct or unethical conduct?
  4. Have you ever been found in violation of performing procedures or practice beyond the scope approved by a licensing or regulatory agency?
  5. Have you ever been subject to informal or formal proceedings by any licensing board, agency or professional association to revoke, suspend, restrict or limit a professional license/registration?
  6. Do you now or have you ever had hospital privileges removed or restricted, or limitation imposed on such privileges or resigned hospital privileges to avoid formal action?
  7. Are you now or have you ever been a party or defendant in any malpractice proceedings settled for \$20,000 or more?
  8. Have you ever been arrested, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome?
  9. Do you currently have or have you had any serious physical or mental condition in the past five years which in any way impairs or limits your ability to practice as a physician assistant with reasonable skill and safety?
  10. Do you currently have or have you had problems with the use of alcohol, stimulants, habit forming and/or illegal drugs in the past five years which in any way impairs or limits your ability to practice as physician assistant 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/certificates were procured 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 associations (past and present) and all government agencies and instrumentalities to release to this licensing Board and 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 practicing as a physician assistant.

I have carefully read the questions in the accompanying application and have answered them completely, without reservation of any kind, and 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 as a physician assistant in the State of Idaho.

I further declare that the photo of me, attached hereto was taken on or about \_\_\_\_\_, 20\_\_\_\_, my age being \_\_\_\_\_.

State \_\_\_\_\_ County of \_\_\_\_\_

(SEAL)

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

Notary Signature \_\_\_\_\_

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

Signature of Applicant \_\_\_\_\_

# SUPERVISING PHYSICIAN FORM



The Supervising Physician must designate one alternate supervising physician to oversee the physician assistant during the supervising physician's temporary absence. Please complete and return form to the Idaho State Board of Medicine, PO Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr. Suite 140, Boise, ID 83704. FAX: (208) 327-7005.

Date Received	Fee/Current	Approved By	Effective date
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Physician Assistant Name \_\_\_\_\_

## SUPERVISING PHYSICIAN

Name \_\_\_\_\_  
Last First Initial

Address \_\_\_\_\_  
Street Telephone  
City State Zip Code Idaho License

I certify that I have read the Rules of the Board of Medicine for Registration of Supervising and Directing Physicians

Signature \_\_\_\_\_

Date of Signature \_\_\_\_\_

*Initial registration fee for primary supervising physician is \$50.00.*

## ALTERNATE SUPERVISING PHYSICIAN

Name \_\_\_\_\_  
Last First Initial

Address \_\_\_\_\_  
Street Telephone  
City State Zip Code Idaho License

I certify that I have read the Rules of the Board of Medicine for Registration of Supervising and Directing Physicians

Signature \_\_\_\_\_

Date of Signature \_\_\_\_\_

***No fee required for registration of alternate supervising physician.***

# CERTIFICATE OF PROFESSIONAL EDUCATION



Please have the following completed by the appropriate educational institution and return directly to the Idaho State Board of Medicine, PO Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr. #140, Boise, ID 83704; Fax: (208) 327-7005. (Note: If additional forms are needed, this form may be duplicated.)

Full Name of Applicant:

Address:

Social Security Number:

Date of Birth:

Baccalaureate Degree

Date of Degree:

**Dates of Attendance:**

**From (Date)**

**To (Date)**

**First Year**

**Second Year**

**Third Year**

**Fourth Year**

As an official of the school named, I certify that the person named above received a degree as noted after fulfilling all requirements.

**PLEASE INCLUDE A COPY OF MY OFFICIAL TRANSCRIPTS**

**(SEAL)**

\_\_\_\_\_  
Please type or print name of Dean/President/Registrar

\_\_\_\_\_  
Signature of Dean/President/Registrar

\_\_\_\_\_  
Name of School or Facility

\_\_\_\_\_  
If changed, present name

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Date of this Certification

\_\_\_\_\_  
Applicant's Signature

# CERTIFICATE OF PHYSICIAN ASSISTANT TRAINING PROGRAM



Please have the following completed by the appropriate program and return directly to the Idaho State Board of Medicine, PO Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr. #140, Boise, ID 83704; Fax: (208) 327-7005.

Full Name of Applicant:	
Address:	
Social Security Number:	Date of Birth:
Degree	Date of Degree:

Dates of Attendance:	From (Date)	To (Date)
First Year		
Second Year		
Third Year		
Fourth Year		

As program director of the school named, I certify that the person named above completed the physician assistant training program as noted.

**PLEASE INCLUDE A COPY OF MY OFFICIAL TRANSCRIPTS**

**(SEAL)**

\_\_\_\_\_  
Please type or print name of Program Director

\_\_\_\_\_  
Signature of Program Director

\_\_\_\_\_  
Name of School or Facility

\_\_\_\_\_  
If changed, present name

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Date of this Certification

\_\_\_\_\_  
Applicant's Signature

CERTIFICATE OF RECOMMENDATION



TO BE COMPLETED BY THE APPLICANT: Two (2) certificates of recommendation are required; please duplicate this form. Recommendations should be from persons who have known the applicant professionally for at least one (1) year.

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Do you request that this information be confidential? \_\_ Yes \_\_ No

TO BE COMPLETED BY RECOMMENDING PERSON. Please complete and return for directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058. Express Mail: 1755 Westgate Drive, #140, Boise, ID 83704; Fax: (208) 327-7005.

TO: Idaho State Board of Medicine:

I have known \_\_\_\_\_ for \_\_\_\_\_ years,  
from \_\_\_\_\_ to \_\_\_\_\_ while he/she was studying  
or practicing as a physician assistant. To the best of my knowledge  
he/she is of good moral and professional character and ethics.

Additional Comments:

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Profession \_\_\_\_\_

## CERTIFICATE OF RECOMMENDATION

**TO BE COMPLETED BY THE APPLICANT:** Two (2) certificates of recommendation are required; please duplicate this form. Recommendations should be from persons who have known the applicant professionally for at least one (1) year.

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Do you request that this information be confidential?  Yes  No

**TO BE COMPLETED BY RECOMMENDING PERSON.** Please complete and return for directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058. Express Mail: 1755 Westgate Drive, #140, Boise, ID 83704; Fax: (208) 327-7005.

TO: Idaho State Board of Medicine:

I have known \_\_\_\_\_ for \_\_\_\_\_ years,  
from \_\_\_\_\_ to \_\_\_\_\_ while he/she was studying  
or practicing as a physician assistant. To the best of my knowledge  
he/she is of good moral and professional character and ethics.

Additional Comments:

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Profession \_\_\_\_\_

# DELEGATION OF SERVICES AGREEMENT



## DELEGATION OF SERVICES AGREEMENT

A Delegation of Services Agreement is to be maintained at each practice site, at the address of record of the supervising physician and at the Board of Medicine. The Delegation of Services Agreement is a written document mutually agreed upon and signed and dated the physician assistant and supervising physician that lists the physician assistant's training, experience and education and defines the working relationship and delegation of duties between the supervising physician and the physician assistant as specified by Board rule. The Board of Medicine will review the written Delegation of Services Agreement and may review job descriptions, policy statements, or other documents that define the responsibilities of the physician assistant in the practice setting, and may require such changes as needed to achieve compliance with these rules, and to safeguard the public.

**The following must be legible. Use additional sheets if necessary. SUBMIT YOUR DELEGATION OF SERVICES AGREEMENT TO THE BOARD WITH YOUR APPLICATION FOR LICENSURE AND WITH ANY CHANGE IN PRACTICE OR SUPERVISION.**

Physician Assistant Name: \_\_\_\_\_

Supervising Physician Name: \_\_\_\_\_

Alternate Supervising Physician(s) Name(s): \_\_\_\_\_

PRACTICE SITE(S): \_\_\_\_\_

1. Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

2. Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**THE FOLLOWING ARE CORE COMPETENCY MEDICAL AND SURGICAL SERVICES APPROVED FOR ALL IDAHO LICENSED PHYSICIAN ASSISTANTS.** The supervising physician may request Board review and approval of specialized procedures not listed in the core competencies by completing Form 6 Page 5.

- Administer medications
- Perform anoscopy
- Apply/remove casts & splints
- Assist in surgery
- Perform bladder catheterization
- Perform Advanced Cardiac Life Support
- Perform CLIA waived lab procedures
- Consult with and referral to appropriate health care resources
- Perform diathermy/ultrasound
- Perform fulguration/cryotherapy of superficial lesions
- Aspirate ganglion cysts
- Incision & drainage of abscesses
- Remove ingrown toenails
- Perform non-ablative laser procedures
- Aspirate and inject small and large joints
- Repair and manage lacerations
- Administer local anesthesia including digital block
- Manage simple fractures excluding reductions
- Insert and remove nasogastric tube
- Order durable medical equipment
- Perform pulmonary function test
- Excision/biopsy of skin or subcutaneous lesions including punch biopsy
- Remove superficial foreign object
- Treat thrombosed hemorrhoids
- Perform venipuncture
- Manage wound care to include irrigation and debridement
- Assist with laser surgery and phototherapy
- Routine gynecological care including pelvic exams, Pap smears, insertion and removal of IUDs



## DELEGATION OF SERVICES AGREEMENT

### PRESCRIPTION AUTHORITY

A physician assistant who wished to apply for prescription writing authority shall submit an application for such purpose to the Board of Medicine.

The drug categories or specific legend drugs and controlled drugs, Schedule II through V that may be prescribed shall be consistent with the regular prescriptive practice of the supervising physician.

***Graduate physician assistants shall not be entitled to issue any prescriptions.***

### CONTROLLED SUBSTANCE PRESCRIBING PRACTICE:

- I will not be prescribing any controlled substances.
- I will be prescribing schedules III through V controlled substances.
- I will be prescribing controlled substances, schedules II through V.

### LEGEND DRUG PRESCRIBING PRACTICE:

I will only be prescribing legend drugs that are within the general scope of family practice. **(Do not list medications)**

In addition, other than controlled substances, I will be prescribing drugs that are **outside** of the general scope of family practice but that are consistent with the regular prescriptive practice of my supervising physician. I have listed those drugs below.

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**Note: The physician assistant with approved prescriptive authority from the Board of Medicine for Schedule II through V drugs must obtain registration from the Federal Drug Enforcement Administration and the Idaho Board of Pharmacy. Forms and a link to the DEA may be accessed on the Board of Pharmacy's website at [bop.idaho.gov](http://bop.idaho.gov).**

### MEDICAL SERVICES REVIEW

Please describe the procedures or protocols for periodic review of a representative sample of records and a periodic review of the medical services being provided by the physician assistant. This review shall also include an evaluation of adherence to the Delegation of Services Agreement.

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**Note: Graduate physician assistants are required to have a weekly record review by their supervising physician.**





## DELEGATION OF SERVICES AGREEMENT

The supervising physician must submit an affidavit attesting to the physician assistant's education, qualifications and clinical abilities to perform the specific specialized procedures being requested on the Specialized Procedures Request Form. **Submit the affidavit only if requesting authorization to delegate specialized procedures not listed in the Core Competencies on Form 6, page 1.** 

### AFFIDAVIT OF SUPERVISING PHYSICIAN

I, \_\_\_\_\_ being first duly sworn, declare under penalty of perjury as follows:

1. I am a physician who holds a current active license issued by the Board of Medicine to practice medicine and surgery or osteopathic medicine and surgery in Idaho and in good standing with no restrictions upon or actions taken against my license.

2. I will be the supervising physician of \_\_\_\_\_, a physician assistant, who holds a current license issued by the Board or will obtain licensure prior to any practice as a physician assistant in Idaho.

3. I have completed the Delegation of Services Agreement with my physician assistant and have reviewed the agreement with the alternate supervising physician.

4. The Delegation of Services Agreement defines the working relationship between me and my physician assistant.

5. I attest to the qualifications and clinical abilities of \_\_\_\_\_, my physician assistant, to perform the specialized procedures listed in the Delegation of Services Agreement in accordance with IDAPA 22.01.03.030.03.

6. A copy of the agreement is on file at each of the practice sites, my address of record and at the Board of Medicine.

\_\_\_\_\_  
SUPERVISING PHYSICIAN

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

Signature \_\_\_\_\_

Notary Public for \_\_\_\_\_ (SEAL)

Commission Expires \_\_\_\_\_

# PHYSICIAN ASSISTANT APPLICATION FOR PRESCRIPTION PRIVILEGES

Please complete and return this form directly to the Idaho Board of Medicine, PO Box 83720, Boise ID 83720-0058. Express Mail: 1755 Westgate Drive, #140, Boise, ID 83704; Fax: (208) 327-7005. Please provide all required documentation.

Applicant's Name: \_\_\_\_\_  
*(Please print or type)*

## SUPERVISING PHYSICIAN AFFIDAVIT

I, \_\_\_\_\_, Supervising Physician for the above named physician assistant, do hereby request that the prescribing privileges, in accordance to IDAPA 22.01.03, Section 042, Para. 1-5 be authorized for

Physician Assistant Name \_\_\_\_\_

I further submit that the prescriptions issued by the physician assistant will be reviewed on a \_\_\_\_\_ basis and shall not exceed those categories described in 22.01.03, Section 042, Para. 01.

\_\_\_\_\_  
Signature – Supervising Physician

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

Signature \_\_\_\_\_

**(SEAL)**

Notary Public for \_\_\_\_\_

Commission Expires \_\_\_\_\_

I hereby request prescription privileges as allowed by IDAPA 22.01.03, Section 042, Para. 1-5 of the Rules for Physician Assistants. I further submit that I have complied with all requirements as listed in IDAPA 22.01.03, Section 042, Para. 1-5. (Attach certified copies of pharmacology courses/training, if it is not reflected in the transcripts.)

\_\_\_\_\_  
Signature –Physician Assistant

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

Signature \_\_\_\_\_

**(SEAL)**

Notary Public for \_\_\_\_\_

Commission Expires \_\_\_\_\_

## VERIFICATION OF LICENSURE/REGISTRATION

Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704; Fax: (208) 327-7005. (If additional forms are needed, this form may be duplicated.)

I am applying for licensure to practice as a physician assistant in the State of Idaho. The Idaho State Board of Medicine requires verification of registration/licensure from each state wherein I hold or have held registration/licensure. This is your authority to release any information in your files favorable or otherwise, directly to the Idaho State Board of Medicine, at the address indicated above.

Applicant's Name: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

My Registration/License No. is: \_\_\_\_\_

State of: \_\_\_\_\_ Registration/License No.: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Name of Registrant/Licensee: \_\_\_\_\_

Issued by: \_\_\_\_\_ Endorsement/Reciprocity with: \_\_\_\_\_

\_\_\_\_\_ Examination (NCCPA)

Status: Current Yes \_\_\_ No \_\_\_ Expiration Date \_\_\_\_\_

Do you have any record of disciplinary or legal action that should be considered with this physician assistant's application? If the identified applicant has a disciplinary record please consider this a request for public record.

Yes \_\_\_ No \_\_\_

Comments:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
State Board

(Board Seal)

***Verification - Not an Endorsement***

**STATEMENT REGARDING DISCLOSURE OF  
SOCIAL SECURITY NUMBERS**

The Idaho State Board of Medicine (hereinafter Board) requires disclosure of social security numbers on all applications for initial licensure and renewal. Disclosure of social security numbers is mandatory for purposes of enforcing child support orders under Idaho Code § 7-1416 and compliance with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank, as required by 45 CFR §§ 61.1 *et seq.* If this Board is required to make a report about an applicant or licensee to the Idaho Department of Health and Welfare or either of these data banks, the report must contain that individual's social security number. Failure to provide a social security number for these mandatory purposes will result in denial of an application for initial licensure or renewal.

An applicant for initial licensure or renewal may also voluntarily disclose his or her social security number for release to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation, such as the Federation of State Medical Boards' Physician Data Center. The Center compiles information about individual applicants and licensees and transmits that information to other licensing boards in order to coordinate licensure and disciplinary activities between the individual States. Such disclosure is for identification purposes only. Social security numbers will not be released for any other purpose not provided for or allowed by law.

I do \_\_\_\_\_ do not \_\_\_\_\_ give the Idaho State Board of Medicine permission to disclose my social security number to other state regulatory agencies, testing and examination vendors, law enforcement agencies, and other private federations and associations involved in professional regulation.

DATED This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Applicant's printed name

### Authorization for Release of Information

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. If you are not authorizing the release of information to a third party, you will **not** need to have this form notarized, just sign and date below.

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 an Idaho license and/or permit 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 an Idaho license and/or permit 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: \_\_\_\_\_

State of: \_\_\_\_\_  
:SS

County of: \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned, a Notary Public in and for said State, personally appeared \_\_\_\_\_, known or identified to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same.

I WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this certificate first above written.

\_\_\_\_\_  
Notary Public for \_\_\_\_\_

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

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



# STATE OF IDAHO

BOARD OF MEDICINE

1755 Westgate Dr., Ste 140  
Boise, Idaho 83704  
(208) 327-7000  
FAX (208) 327-7005  
E-Mail [info@bom.idaho.gov](mailto:info@bom.idaho.gov)  
Website [bom.idaho.gov](http://bom.idaho.gov)

## Credit Card Transmittal Form

~Print Legibly~

Order Information: \_\_\_\_\_  
(Description of what & who payment is for)

Name as it appears on card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Type of Card      MasterCard      Visa

Expiration (mm/yy) \_\_\_\_\_ Authorized Charge Amount: \_\_\_\_\_

*If you would like to receive a receipt of this transaction, provide your email address below.*

Email Address: \_\_\_\_\_

All fields (except email) are required in order to process payment/order.