

**IDAHO STATE BOARD OF MEDICINE**

1755 Westgate Drive, Suite140 • Boise, ID 83704 • (208) 327-7000



FOR USE OF THE BOARD				
Approved By	Date	Reg. No.	Fees	Received

**No practice is permitted prior to issuance of registration number. Applicants are advised not to enter irrevocable contracts, purchase or sales agreements, on the assumption that registration will be granted.**

**I hereby apply for registration as a: ..... PHYSICIAN ASSISTANT TRAINEE – Fee \$10**



*(Please type or print legibly)*

First Name	Middle Name	Last Name
Current Address <i>(Street, City, State, Zip)</i>		Social Security No.
Place of Birth		Date of Birth <i>(Month/Day/Year)</i>
Email Address		Telephone

EDUCATION	NAME	LOCATION <i>(CITY/STATE)</i>	DATES	DEGREE
PA PROGRAM			TO	
POSTGRADUATE			TO	

**Include with this form:**

- 1) Name, address, start and end dates, and description of the course of study for **all rotations** in Idaho. Please provide on a separate sheet.
- 2) Summary information regarding the following: Criminal charges or conviction (regardless of the outcome), medical disciplinary actions, malpractice actions, if any. Please provide on a separate sheet.

Applicant's Signature <b>X</b>	Date	
<b>PROGRAM DIRECTOR STATEMENT</b> I hereby certify that the above named physician assistant is currently enrolled in an accredited/approved physician assistant program.	Supervisor must be an Idaho licensed practitioner and must complete the section below. <b>SUPERVISOR AFFIDAVIT</b> Applicant will work under my personal supervision and I assume responsibility for the applicant's work.	
Name of Program Director <i>(Please Print)</i>	Rotation Start & End Date  _____ to _____	
Signature of Program Director <b>X</b>	Name of Supervisor/Proctor <i>(Please Print)</i>	
Program Name	Signature of Supervisor/Proctor <b>X</b>	
Telephone	Name of Practice Site	License #
Address	Date	Address
		Date

**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.