

IDAHO STATE BOARD OF MEDICINE

P.O. Box 83720 • Boise, ID 83720-0058 • (208) 327-7000
Express Mail: 1755 Westgate Drive, Suite140 • Boise, ID 83704

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

I hereby apply for registration as a:

PHYSICIAN ASSISTANT TRAINEE – Fee \$10

Make check(s) payable to: IDAHO STATE BOARD OF MEDICINE

(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, Date, Year</i>)
Email Address		Telephone

EDUCATION	NAME	LOCATION	DATES	DEGREE
COLLEGE/UNIV.				
PA PROGRAM				
POSTGRADUATE				

Include with this form:

- 1) Name, address, 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.

Registration is requested from _____ to _____			
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	Registration # SPHY-	Name of Practice Site	License #
Address	Date	Address	Date

SUPERVISING PHYSICIAN FORM

Primary Supervising Physicians supervising **physician assistant trainees** must hold current registration as a primary supervising physician with the Board of Medicine. 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. *(This form may be duplicated for multiple rotations)*

Date Received

Fee/Current

Approved By

Effective date

Physician Assistant Trainee 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 (not required if already registered).

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.