

## 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	DATES	DEGREE
COLLEGE/UNIV.				
PA PROGRAM				
POSTGRADUATE				

**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 (Please Print)	Rotation Start & End Date _____ to _____	
Signature of Program Director <b>X</b>	Name of Supervisor/Proctor (Please Print)	
Program Name	Signature of Supervisor/Proctor <b>X</b>	
Telephone	Name of Practice Site	License #
Address	Date	Address
		Date