



# 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 Allied Health Licensure

**Please note:** should your license be issued to you on or before March 30, you will be required to renew by June 30 of that year. If you do not receive a license until after that date, you will not be required to renew until June of the following year.

ja

## GENERAL CHECKLIST RT FOR APPLICANTS

\*\* Questions? E-mail [claudia.lawson@bom.idaho.gov](mailto:claudia.lawson@bom.idaho.gov) \*\*

Fee must accompany application. **APPLICATION WILL NOT BE PROCESSED UNLESS ACCOMPANIED BY THE APPROPRIATE FEE.** Fee amount due will be indicated on application. Checks or money orders are to be made payable to the Idaho State Board of Medicine. *Fees are nonrefundable.*

**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 1-8. Provide details, for *YES* answers, on a separate sheet. Court documents will be required, if applicable.

**Photo(s)** – 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 acceptable.

**Notarized** – Application must be notarized and signed in the appropriate place.

**Certificate of Professional Education (Form 1):** Fill in the top section. Be sure to indicate the degree **and** the field of study, the date degree was received, and sign **at the bottom** of the section. Send this form to the school (Registrar or Program Director) where applicant received professional education. The school will then send the form to the Board of Medicine.

**Certificates of Recommendation (Form 2 & 3):** Fill in the top section. Send this form to **two** individuals who have known the applicant professionally for at least **one** year (**no relatives**). Recommendations must be on the form provided or on letterhead addressed to the Board. Names and addresses must be legible.

**Verification of Licensure/Registration (Form 4):** This form may be duplicated. This is required from **every state** where the applicant has ever held a license/registration and must come directly from the state to the Board. **NOTE:** Most states require a fee for this service, paid in advance. It is strongly suggested that you contact the state(s) prior to sending your request to prevent delays and to determine the best way to send required fees.

**Verification of National Certification/Registration:** Must come directly from NBRC to the Board of Medicine. [www.nbrc.org](http://www.nbrc.org)

**FAXED** and emailed supporting documents can be accepted, but the hard copy 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 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 - RESPIRATORY THERAPY LICENSURE**

<i>FOR USE OF THE BOARD</i>					
1. Prof. Education	2. Recommendation	3. Recommendation	4. Verification	NBRC	Received
6. T/P Supervisor	NPDB-HIPDB	SSN Disclosure			Fee

I hereby apply for:

- Respiratory Therapy Licensure** - Fee \$100  
 **Temporary Permit** - Fee \$100

**Please note:** should your license be issued to you on or before March 30, you will be required to renew by June 30 of that year. If you do not receive a license until after that date, you will not be required to renew until June of the following year.

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



<b>First Name</b>		<b>Middle Name</b>		<b>Last Name</b>	
<b>Address</b> ( <i>Street, City, State, Zip</i> )				<b>Telephone</b>	
<b>Email Address</b>				<b>Social Security No.</b>	
<b>Place of Birth</b> ( <i>City and State</i> )				<b>Date of Birth</b> ( <i>Month/Day/Year</i> )	
<b>Height</b> ( <i>Ft., In.</i> )	<b>Weight</b>	<b>Hair</b>	<b>Eyes</b>	<b>Complexion</b>	<b>Sex:</b> Male Female
<b>NAME AND LOCATION</b> ( <i>CITY/STATE</i> ) <b>OF SCHOOLS</b>		<b>FROM</b> ( <i>Month/Day/Year</i> )		<b>TO</b> ( <i>Month/Day/Year</i> )	
<b>High School</b>					
<b>College/University</b>					
<b>Respiratory Therapy 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 beginning with the month applicant graduated from college up to the present time leaving no gap in time of more than one month (e.g. employed, unemployed, studying for the exam, military service, extended vacation, etc). Attach additional pages if necessary.

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

<p style="text-align: center;"><b>NOTE</b> </p> <p>Attach a finished photograph of your head and shoulders only. Photo must have been taken within the last year and be 3"x4" in size.</p> <p><b>Proof photos, negatives, copies, and instant photos are not acceptable.</b></p> <p style="text-align: center; color: yellow; background-color: black; padding: 2px;"><b>DO NOT STAPLE PHOTO TO APPLICATION</b></p>	<p style="text-align: center;"><b>CERTIFICATION</b></p> <p><b>IF THE ANSWERS TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.</b> </p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 10%; text-align: center;">Y</th> <th style="width: 10%; text-align: center;">N</th> <th style="width: 75%;"></th> </tr> </thead> <tbody> <tr> <td>1.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Have you ever failed a licensure exam?</td> </tr> <tr> <td>2.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Have you ever been refused a professional license/registration?</td> </tr> <tr> <td>3.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Have you ever been arrested, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome?</td> </tr> <tr> <td>4.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>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?</td> </tr> <tr> <td>5.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>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?</td> </tr> <tr> <td>6.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>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 respiratory therapist with reasonable skill and safety?</td> </tr> <tr> <td>7.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Do you now or have you ever had employment terminated or restricted, or limitations imposed on such employment or resigned from employment to avoid formal action?</td> </tr> <tr> <td>8.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>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 a respiratory therapist with reasonable skill and safety?</td> </tr> </tbody> </table>		Y	N		1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever failed a licensure exam?	2.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been refused a professional license/registration?	3.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been arrested, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome?	4.	<input type="checkbox"/>	<input type="checkbox"/>	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?	5.	<input type="checkbox"/>	<input type="checkbox"/>	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.	<input type="checkbox"/>	<input type="checkbox"/>	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 respiratory therapist with reasonable skill and safety?	7.	<input type="checkbox"/>	<input type="checkbox"/>	Do you now or have you ever had employment terminated or restricted, or limitations imposed on such employment or resigned from employment to avoid formal action?	8.	<input type="checkbox"/>	<input type="checkbox"/>	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 a respiratory therapist with reasonable skill and safety?
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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 respiratory therapist.

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 respiratory therapist 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 \_\_\_\_\_

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

(SEAL) Notary Signature \_\_\_\_\_

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

\_\_\_\_\_  
Signature of applicant



# CERTIFICATE OF RECOMMENDATION



I am applying for licensure to practice as a **respiratory therapist** in the State of Idaho. Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, Idaho 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704; Fax: (208) 327-7005. (Note: Two certificates of recommendation are required. Please duplicate this form.) Recommendations should be from persons who have known the applicant professionally for at least one year.

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

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

\_\_\_\_\_

Do you request that this information be confidential?  Yes  No

TO: Idaho State Board of Medicine:

I have known \_\_\_\_\_ for \_\_\_\_\_ years,  
from \_\_\_\_\_ to \_\_\_\_\_ while he/she was studying  
or practicing as a respiratory therapist. 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

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

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

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Additional Comments:

Signature \_\_\_\_\_

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

Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Profession \_\_\_\_\_

## 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 respiratory therapist 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 (NBRC)

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

Do you have any record of disciplinary or legal action that should be considered with this respiratory therapist's application? 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

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## 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.