

# IDAHO STATE BOARD OF MEDICINE

PO Box 83720 • Boise, ID 83720-0058  
 (208) 327-7000 • FAX (208) 327-7005

FOR USE OF THE BOARD

Received
Reg. No.
Approved By
Date

I hereby apply for renewal of registration as a:

- MEDICAL RESIDENT**  
 **MEDICAL STUDENT/EXTERN**

(Please type or print)

First Name	Middle Name	Last Name
Public Address (Street)	(City, State, Zip)	*Social Security No.
*Confidential Address (Street)	(City, State, Zip)	*Date of Birth (Month/ Day/ Year)
*Email Address	*Telephone	

EDUCATION	NAME	LOCATION	DATES	DEGREE
MEDICAL SCHOOL				
POSTGRADUATE				

Include with this form 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
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Supervision is to be from \_\_\_\_\_ to \_\_\_\_\_

**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 Primary Supervising Physician  <b>X</b>		Signature of Alternate Supervising Physician  <b>X</b>	
Address	Date	Address	Date

\*Confidential-for Board Staff use only.