State of Idaho
Division Of Occupational and Professional Licenses

Board of Medicine
PO Box 83720
Boise, Idaho 83720-0063
(208) 327-7000

Fax (208) 327-7005
E-Mail hp-licensing@dopl.idaho.gov
Website dopl.idaho.gov

Instructions for Completing the Online Idaho Licensure Application

Practice of medicine is not permitted prior to issuance of a license. APPLICANTS ARE ADVISED NOT TO ENTER IRREVOCABLE CONTRACTS, PURCHASE OR SALE AGREEMENTS, ON THE ASSUMPTION THAT LICENSURE WILL BE GRANTED.

Review the following instructions prior to completing the application. Failure to submit all required information and documentation will result in processing delays. In completing the online application, you will be asked to list chronology beginning with medical school graduation through the present leaving no gaps greater than 30 days, complete the Malpractice Liability Claims History section, disclose any disciplinary actions, and any criminal history. including employment histories, and information on malpractice claims, if applicable. Having this information on hand before you begin your session will facilitate completing your online application.

Idaho requires all applicants to provide their social security number. If not included, your application cannot be accepted, and the process will be delayed.

If you have any questions about the information provided regarding the application packet, please send an email inquiry to hp-licensing@dopl.idaho.gov.

Fees

Once received, your application will be reviewed and a letter requesting the application fee will be sent. The Idaho State Board of Medicine application fee is $200 (non-refundable), to be paid by check, money order, or credit card. Payment is required for processing of the application passed initial setup. After the application has been completed and approved, notification of prorated licensing fees will be sent. These final licensing fees are accessed to bring all license expiration dates into concurrence with the next scheduled renewal cycle.

Criminal Background Check

Idaho requires a criminal background check prior to licensure. A fingerprint card provided by the Board and instructions will be mailed to the home address provided on the application as required by the FBI. Third party involvement is not permitted at any point during this process. The fingerprint card must be returned directly to the Idaho State Board of Medicine from the applicant's residence along with payment and any other necessary documents. **Home addresses are kept confidential and used for Board purposes only.**

The Uniform Application for Physician State Licensure (UA)

The Uniform Application is the licensure application required by the Board. After completing the UA for the first time, your application is securely stored and can be sent to another participating board as long as the forms and state-specific requirements are also completed for each board. Updates to the UA can be made as needed.

To begin or update your UA (licensure application), visit https://www.fsmb.org/uniform-application/ and click on the UA graphic, then sign in. You may also visit http://www.fsmb.org/ and click on Uniform Application in the licensure menu to access the portal page. Complete as instructed in each section.

If you experience difficulties in completing the Uniform Application, visit the Uniform Application FAQ at http://www.fsmb.org/uniform-application/ua-faq/. If your question is not listed, contact UA customer service at 800-793-7939 or ua@fsmb.org. Provide your username and FCVS ID number or nine-digit Federation ID (FID). If an error message is received, send a screenshot of the error or the description to ua@fsmb.org.

The Federation Credentials Verification Service (FCVS)

The Federation Credentials Verification Service (FCVS) can be used for credentials verification as part of the licensure by exam process. Existing FCVS profiles are accepted, provided that your profile is designated to be received by the Idaho Board. If you do not have an existing FCVS profile and are considering using FCVS for credentials verification note the Idaho Board does not require the FCVS. The Board accepts all verification packets and recommends the FCVS for International Medical Graduates.

To work on the FCVS application (different and separate from the Uniform Application), visit https://www.fsmb.org/fcvs/ and click on the FCVS graphic, then sign in. You may also visit http://www.fsmb.org/ and click on FCVS in the Licensure menu to access the portal page. For assistance, use the messaging tool within FCVS or call 888-275-3287 with your FCVS ID number.

Licensure by Endorsement – in accordance with IDAPA 24.33.03.102

An applicant, in good standing and having no disciplinary actions taken against their ability to practice medicine and surgery in a state, territory or district of the United States or Canada is eligible to apply for licensure by endorsement to practice medicine in Idaho.

An applicant with any disciplinary action, whether past, pending, public or confidential, by any board of medicine, licensing authority, medical society, professional society, hospital, medical school or institution staff in any state, territory, district, or country is not eligible for licensure by endorsement. An eligible applicant for licensure by endorsement fulfills all requirements of IDAPA 24.33.03.102.

To qualify for licensure by endorsement you must:

1. Hold a current license to practice medicine in another U.S. state or Canada that has no disciplinary action, suspension, or restrictions **or** be currently ABMS or AOA board certified.

2. Disclose on the application form any condition that impairs your judgment or that would otherwise adversely affect your ability to practice your medical profession with reasonable skill or safety? Please note - If you are receiving appropriate treatment that allows you to practice safely and without impairment, you may answer No.

3. Disclose any significant (over $250,000) malpractice settlements or judgements in the past 10 years or 3 malpractice judgments or settlements of any dollar amount in the past 5 years.

4. Complete an affidavit affirming your eligibility and criminal background check.

Osteopathic physicians and surgeons receiving degrees after January 1, 1963 and fulfilling applicable requirements may apply for a license by endorsement.

The Florida medical licensing examination, from July 1969 through 1980, and the Puerto Rico medical licensing examination do not meet the requirements for licensure by endorsement.

Eligible applicants for licensure by endorsement will need to complete the checklist items on the following page:

Endorsement Licensure Checklist

Complete an online Uniform Application (UA) and Attestation Questions.	☐
Receive acknowledgement packet sent by the Board.	☐
Complete and mail fingerprint card, application fee of $200.00 and all required forms to the Board directly.	☐
Pay prorated fees once notified by Board staff.	☐

Please note the following:

If not pre-filled, provide your home address, (required), and a separate address for business or postgraduate training. Both Board Contact and Public Access selections must be made but you can use the same address for each selection. All home addresses must be domestic, as fingerprint cards and other background information are mailed there.

- Enter your full social security number (required) and **not** the USMLE number.

- Enter each training program in the United States and Canada in either the ACGME Training page or the Other Training page. Enter postgraduate programs outside of the United States and Canada on the Chronology page.

- You are not able to add or edit MD or DO license information in the UA because that information is sent directly from the state boards into the FSMB system. If changes are needed, email ua@fsmb.org with the correct information. Depending on volume of license update requests, it may take 1-3 business days for the changes to appear in your UA. Do not enter MD or DO license information under “Other”.

- If you hold a medical or osteopathic license or licenses in countries outside of the United States or Canada, provide that information on a separate sheet of paper to the Board.

- Your chronology of activities should cover each of your activities (non-working time included) from medical school graduation to present. Previously listed medical school and postgraduate training programs will pre-fill the chronology. Do not leave gaps greater than 30 days. For each entry, use the first day of the month for start and end dates unless you know the exact date. If you have military or locum tenens assignments, list each location separately.

- Clinical time indicates time spent seeing patients and practicing medicine. Administrative time indicates time spent on paperwork, research, or teaching.

- Leave the malpractice liability claims section blank only if you have had no claims. List all pending or dismissed claims.

- Upon accepting the terms and agreement and submitting the UA, first time UA users will be taken to a payment page for the one-time service charge. This charge sustains the UA program and is separate from FCVS and state board licensing fees.

- For a copy of your receipt, click on the “Home” link to return to the portal page, which will now have a Payment link to all FSMB receipts in the upper right corner.

- To open your UA for editing and resubmitting to a board, or for submitting to a new board, sign in and choose the appropriate board in the State Board section. Reselect the US Citizen query on the Identification page (it resets each time a UA is submitted), make changes as needed, then submit or resubmit your UA.

- Refer to the UA FAQ at http://www.fsmb.org/uniform-application/ua-faq/ for answers to the most common UA questions. If your issue isn't listed, contact UA customer service at 800-793-7939 or email ua@fsmb.org with your username and a description of your issue. If you receive an error, provide a screenshot for each error or the description to ua@fsmb.org.

If you are not using FCVS for credentials verification: (License by Exam)

- Send to the Board a certified copy of a legal name change document (marriage certificate, divorce decree, court order) if applicable.

- Contact each appropriate examination entity to have a certified transcript of your scores sent directly from the exam entity to the Board. If you have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), request your transcript of scores from the NBME. For exam entity contact information, see the UA FAQ at http://www.fsmb.org/uniform-application/ua-faq/. All exam transcripts are required, even if exam course was not completed.

- Complete the UA Medical Education Verification and Postgraduate Training Verification forms as directed on each form.

- If you are an international medical graduate, request from ECFMG that your ECFMG status report be sent to the board, as applicable. See the UA FAQ at the link on the previous page for contact information.

Uniform Application License by Exam Checklist – Idaho Board of Medicine

	NOT using FCVS to verify credentials	Using FCVS to verify credentials
1. Completed online application (UA) and Attestation Questions. ****** Please be sure to enter your full social security number and not the USMLE # in the appropriate field. ******	☐	☐
2. Fingerprint card (to be provided from the Board after UA is submitted) completed and returned.	☐	☐
3. Complete and return applicable portions of State Addendum Part 2.	☐	☐
4. Application fee of $200.00 sent to Board.	☐	☐
5. Completed "Affidavit and Authorization for Release of Information" form submitted to the Board.	☐	☐
6. Proof of Identity (copy of birth certificate or current passport) and supporting documentation of any legal name change sent to the Board.	☐	Completed via FCVS
7. Medical Education Verification form (Form #1) sent to the Board by all medical schools attended	☐	Completed via FCVS
8. Medical School Transcripts sent to the Board by your medical school.	☐	Completed via FCVS
9. Postgraduate Training Verification form (Form #2) required from all ACGME certified programs you attended.	☐	Completed via FCVS
10. All Examination Transcripts sent to the Board.	☐	Completed via FCVS
11. ECFMG (if applicable) Status Report sent to the Board.	☐	Completed via FCVS

State Addendum Part 2 Instructions

Complete the addenda as instructed below. Return the completed forms to the Idaho State Board of Medicine.

☐ **Addendum 2.1 – Additional Physician Information.** To be completed by the applicant.

☐ **Addendum 2.2 – Authorization for Release of Information.** To be completed by the applicant with the name(s) of any other individual(s) or entity(ies), besides the applicant, with whom this Board may discuss the status of the pending application, i.e., spouse, staff members, or other third parties and returned with the application. Without this completed form the Board may discuss the pending status **only** with the applicant.

☐ **Addendum 2.3 - Affidavit for Licensure by Endorsement.** This form will need to be completed **only** if you are applying for licensure by endorsement. Return the completed form to the Idaho Board.

Addendum 2.1

Additional Physician Information

Do not leave blank and please print clearly

Full Name: _____

Contact Numbers: Telephone: (___) _____ Cell: (___) _____

Physician's E-mail: _____

Please provide the following information:

Name of Employer: _____

Anticipated practice location and address:

_____

Anticipated start date: _____

Type of practice:
___ Locum Tenens
___ Telehealth
___ Hospital
___ Clinic
___ Other: (Please describe) _____

Please access the Idaho State Board of Medicine's website at https://elitepublic.bom.idaho.gov/IBOMPortal/BoardAdditional.aspx?Board=BOM&BureauLinkID=320 and select the links on the right to review Licensure Laws, Rules and Policy & Position Statements.

"I have carefully read all licensure laws and rules pertaining to practicing medicine in Idaho as follows (Check the boxes of each document you have reviewed):

☐ Medical Practice Act, Idaho Code Chapter 18, Title 54—in its entirety.

☐ Discipline portion of Medical Practice Act, Idaho Code Section 54-1814.

☐ Telehealth Access Act, Idaho Code Chapter 57, Title 54.

☐ IDAPA 24.33.01 (General Licensure Rules) and IDAPA 24.33.03 (General Provisions, including Rules Relating to Telehealth); and

☐ 'BOM Guidelines for the Chronic Use of Opioid Analgesics.'" https://elitepublic.bom.idaho.gov/IBOMPortal/BoardAdditional.aspx?Board=BOM&BureauLinkID=320

Signed Under Penalty of Perjury, this _____ day of _____, 20___.

_____
Signature

Addendum 2.2

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, with whom this Board may discuss the status of the pending application, i.e., spouse, staff members, or other third parties and returned with the application. **Without this fully completed form, the Board may discuss the pending status only 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):

1._____
First Name Last Name Relationship to Applicant

_____
Name of En ity (University, Hospital, etc)

_____ _____
Telephone Number Email Address

2._____
First Name Last Name Relationship to Applicant

_____
Name of En ity (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 medical license to practice medicine and surgery 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 regarding my filed application for an Idaho medical license to practice medicine and surgery 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

Applicant 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 _____, M.D./D.O., 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.
IN 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: _____

Addendum 2.3

AFFIDAVIT FOR LICENSURE BY ENDORSEMENT

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS **YES**, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.

	YES	NO	
1.	☐	☐	Do you now hold a current, valid, unrevoked, unsuspended, undisciplined license to practice medicine and surgery in a state, territory or district of the United States or Canada?
2.	☐	☐	Do you now hold current board certification by a specialty board approved by the American Board of Medical Specialties or AOA?
3.	☐	☐	Have you had any disciplinary action on your license to practice medicine, whether past, pending, public or confidential, by any board of medicine, licensing authority, medical society, professional society, hospital, medical school or institution staff in any state, territory, district or country?
4.	☐	☐	Do you have pending or had medical malpractice actions against you within the last ten (10) years, and the judgments or settlements, if any, of such claims exceeded two hundred fifty thousand dollars ($250,000), or three (3) malpractice judgments or settlements of any dollar amount in the past five (5) years?

I _____, MD/DO, 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, particularly in regard to licensure by endorsement pursuant to IDAPA24.33.03.102; that I am the lawful holder of the degrees/credentials listed, and that such degrees/credentials 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 any 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 practice of medicine and surgery during the time that I am a licensee of this Board.

I have carefully read the questions in the accompanying application and have answered them completely, without reservation of any kind, and I 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 the denial, suspension, or revocation of my license to practice medicine and surgery in the State of Idaho.

Applicant's signature: _____ MD/DO Date: _____, 20____.

STATE OF _____)
: ss
County of _____)

On this _____ day of _____, 20_____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, M.D./D.O., 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.

IN 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: _____

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at http://www.fsmb.org/policy/contacts.

Please send this form to: Idaho State Board of Medicine
PO Box 83720
Boise, ID 83720-0063

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant Photograph

Securely tape or glue a recent (per the board's instructions) front-view 2" x 2" passport-type color photo of yourself in this square.

_____
Applicant's signature (must be signed in the presence of a notary)

_____
Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

_____
Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of _____, County of _____,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 20____.

Notary Public Signature _____ My Notary Commission Expires _____

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Medical or Osteopathic School Verification Form

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician's transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name _____ Last name _____ Practitioner Type ☐ MD ☐ DO ☐ ____

Middle name _____ Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) _____

Name if different when diploma awarded: _____

Name of school _____

**The social security number is to be used for purposes of identification only and may not be used or any other reason.*

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name	Idaho State Board of Medicine
Mailing address	PO Box 83720
City/State/Zip	Boise, ID 83720-0063

Applicant signature _____ Date _____

Section 2: Medical or Osteopathic School Verification

School name _____

Complete address w/country _____

School name if different when applicant attended _____

Hours of undergraduate education required for admission _____ Total weeks of education applicant attended _____

Attendance (mm/yyyy) from _____ to _____ Graduation date _____ Degree awarded _____

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual's medical or osteopathic education. Check the appropriate responses and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her medical/osteopathic education? **If yes,** indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved. Yes ☐ No ☐

☐ Personal or family	From _____ to	☐ Approved	☐ Unapproved
☐ Academic remediation	From _____ to	☐ Approved	☐ Unapproved
☐ Health	From _____ to	☐ Approved	☐ Unapproved
☐ Financial	From _____ to	☐ Approved	☐ Unapproved
☐ Participation in a joint degree program	From _____ to	☐ Approved	☐ Unapproved
☐ Participation in a non-research special study (e.g., fellowship, intl. experience)	From _____ to _____	☐ Approved	☐ Unapproved
☐ Other _____	From _____ to _____	☐ Approved	☐ Unapproved

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? **If yes,** indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

☐ Academic	From _____ to	☐ Documentation attached
☐ Unprofessional conduct	From _____ to	☐ Documentation attached
☐ Behavioral reasons	From _____ to	☐ Documentation attached
☐ Other _____	From _____ to _____	☐ Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☐

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature _____
Print name _____
Title _____ Date _____
Phone number _____ Fax number _____
Email _____

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Please mail this completed form and any other items to the board at the address listed in Section 1. Thank you.

UA UNIFORM APPLICATION FOR LICENSURE

Postgraduate Training Verification Form

Institution Name: ______________________________

Institution Address: ______________________________

____

Affiliated School: ______________________________

Applicant: Do not complete this form for verification of accredited training if you are using FCVS. FCVS does not verify non-accredited training. When using FCVS, use this form only if your licensing board requires verification of non-accredited training.

Program Director or designated Official: Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

Section 1:
To be completed by the Applicant.

Name: ______________________ **Suffix** _____ **Practitioner type: M.D.** ☐ **D.O.** ☐

Date of birth: __________ **(mm/dd/yyyy)** **SSN*** ______________________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Name if different when diploma awarded: ______________________

Board Information: To be completed by the applicant.

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any all information pertaining to my training there to the board listed below:

Board Name: Idaho State Board of Medicine
Mailing address: PO Box 83720. Boise, ID 83720-0063

Applicant Please Sign Here →
Applicant Signature ______________________ **Date** __________

Section 2 :
Program Participation :

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected comple ion date in the "To" field.

Use one section per Department/Specialty. If he Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Report Internships, Residencies and Fellowships separately.

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/Subspecialty: ______________________
From: __/__/____ **To:** __/__/____
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/Subspecialty: ______________________
From: __/__/____ **To:** __/__/____
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐Internship
☐Residency
☐Chief Residency
☐Fellowship
☐Research

Specialty/Subspecialty: ______________________
From: __/__/____ **To:** __/__/____
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper.
Attach pages as needed.

1. Did this individual ever take a leave of absence or break from his/her training? ---------------- ☐Yes ☐No
2. Was this individual ever placed on probation? -- ☐Yes ☐No
3. Was this individual ever disciplined or placed under investigation? -------------------------------- ☐Yes ☐No
4. Were any negative reports for behavioral reasons ever filed by instructors? -------------------- ☐Yes ☐No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ---------------- ☐Yes ☐No

Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form. This section MUST be signed by the program director (M.D. or D.O. only). **(Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)**

Signature: ______________________

Print name: ______________________

Title: ______________________

Email address: ______________________

Phone Number: ______________________ **Date:** __________