ATHLETIC TRAINER APPLICATION INSTRUCTIONS

FEES

- Application Fee: AT - $150; Provisional AT - $80
  - Mail application fee with application.
  - Payment can be by check, money order (payable to IDAHO STATE BOARD OF MEDICINE), or credit card (Credit Card Transmittal Form included)
- Application and all license fees are non-refundable.

APP1

- Check the box for either Athletic Trainer or Provisional AT (has graduated but has not passed National Exam).
- Complete all sections.
- If Applicant has not applied for registration/licensure in other states, write "Not Applicable" in the appropriate section.

APP2

- Complete all sections.
- History cannot have any gap of more than one month. Attach additional sheets for history, if necessary.
- Answer all questions 1-8.
  - Provide details, for YES answers, on a separate sheet.
  - YES answers will require additional documentation (DD-214, court documents, etc.).
- Application must be signed by Applicant and notarized by a notary public.

The above items cannot be faxed or emailed.

The items listed below are to be requested by Applicant and can be faxed or emailed. FAX: 208-334-3536; Email: BOM-Licensing@dopl.idaho.gov

EDU1 (VERIFICATION OF PROFESSIONAL EDUCATION)

- Complete Applicant section only.
- Form must be signed by Applicant.
- Send this form to institution where Applicant completed their degree in athletic training.
  - Registrar/Program Director **must** return completed form **directly** to the Board of Medicine.

NATIONAL EXAM VERIFICATION

- Applicants for full AT licensure must request verification from the NATABOC.
  - NATABOC Website: www.bocatc.org
- Verification must be sent from the NATABOC **directly** to the Board of Medicine.

VERIFICATION OF REGISTRATION/LICENSURE

- Required from all states in which Applicant holds or has held licensure/registration.
- Verification must be sent from the state of licensure **directly** to the Board of Medicine.

DPHY1 (DIRECTING PHYSICIAN REGISTRATION FORM)

- Complete Athletic Trainer section only.
- Primary directing physician must be a currently licensed Idaho physician.
- Must be completed and signed by Primary Directing Physician.

SPOP1-AFF (AT SERVICE PLAN OR PROTOCOL-AFFIDAVIT)

- Complete top section.
- Check Box 1 if Applicant already has an offer of employment.
- Form must be signed by Applicant and Directing Physician(s) and notarized by a notary public.
  - If Box 2 is checked, form needs to be signed by Applicant only and notarized by a notary public.

SPOP1, PAGES 1-4 (AT SERVICE PLAN OR PROTOCOL)

- **Do not submit** SPOP1, PAGES 1-4 to the Board with your application for licensure.

PROV1 (SUPERVISOR AFFIDAVIT)

- Applicants that have not yet passed the NATABOC exam and are applying for a **provisional** license must submit this form.
- Complete Applicant section only.
- Supervisor must be a currently licensed Idaho athletic trainer.
- Must be signed by Supervisor and notarized by a notary public.

AUTH1 (Authorization for Release of Information)

- Required to release information to individual(s) other than Applicant.
- Must be signed by Applicant and notarized by a notary public.

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.
Incomplete applications are held for up to 1 year, after that, all documents will be destroyed.

State of Idaho
Division Of Occupational and Professional Licenses
Board of Medicine

BRAD LITTLE
Governor
RUSSELL BARRON
Administrator

11341 W Chinden Blvd.
P.O. Box 83720
Boise, ID 83720-0063
(208) 334-3233
dopl.idaho.gov

CREDIT CARD TRANSMITTAL FORM

For security of your financial information, please do not email this form to the Board.

Please type or print legibly

Order Information: _____
(Description of what and 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 Date: _____ /_____
(MM) (YY)

I authorize the Idaho Board of Medicine to charge the above credit card for a one-time payment in the amount of $ _____ .

Printed Name: _____

Authorized Signature: _____

Please Note: The Board of Medicine does not retain your credit card information.

If you would like to receive a receipt of this transaction, provide your email address below.

Email Address: _____

IDAHO STATE BOARD OF MEDICINE

P.O. Box 83720 · Boise, ID 83720-0063 · (208) 327-7000
Express Mail: 11341 W Chinden Blvd, Bldg 4 · Boise, ID 83714

APPLICATION – ATHLETIC TRAINER LICENSURE

FOR USE OF THE BOARD					
EDU1	NATABOC	VER	DPHY1	SPOP1-AFF	Received
PROV1 *(AT Supervisor)*		NPDB	AUTH1		

☐ Athletic Trainer - $150

☐ Provisional AT *(has not passed National Exam)* - $80

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.

Before completing, please read instructions.

First Name	**Middle Name**	**Last Name**
Current Mailing Address (*Street*)		**Telephone**
(*City, State, Zip*)		**Alt. Telephone**
Public Address (*Street*)		**Social Security No.**
(*City, State, Zip*)		**Date of Birth** (*Month/Day/Year*)
Email Address		**Sex:** Male ☐ Female ☐

NAME AND LOCATION *(CITY/STATE)* **OF SCHOOLS**	**FROM** *(Month/Year)*	**TO** *(Month/Year)*
AT Program		
Postgraduate Study		

NATABOC Certification Number: _____

LIST ALL LICENSURE/REGISTRATION IN STATES AND/OR COUNTRIES *(below)*	**Year**	**GRANTED**		**CURRENT**		**NUMBER**
		Yes	**No**	**Yes**	**No**	

In chronological order, account for all periods of time from completion of professional school to present **leaving no gap in time of more than one month.** Include post-graduate study, private practice, military service, etc. Attach additional pages if necessary.

FROM (Month/Year)	**TO** (Month/Year)	**NAME OF INSTITUTION OR PLACE OF PRACTICE**	**LOCATION** (City, State)

NOTE

Tape a finished photograph of your head and shoulders only. Photo must have been taken within the last year and be 2"x2" passport to 3"x4" in size.

DO NOT STAPLE PHOTO TO APPLICATION

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

Y	**N**	
☐	☐	1. Are you in active service in the U.S. Military, an honorably discharged U.S. Military veteran, or a spouse of either one? *(If so, please be prepared to provide additional documentation)*
☐	☐	2. Have you ever failed a licensing examination for a professional license/registration?
☐	☐	3. Have you ever had an application for a professional license/registration denied or refused?
☐	☐	4. Have you ever been investigated by any licensing board, hospital, healthcare organization, agency or professional association in connection with incompetency, practice act violations, unprofessional conduct or unethical conduct *(even if no action resulted from the investigation)*?
☐	☐	5. Have you ever been found in violation of performing procedures or practicing beyond the scope approved by a licensing or regulatory agency?
☐	☐	6. Are you now or have you ever been a defendant in any malpractice proceedings, regardless of the outcome?
☐	☐	7. Have you ever been arrested, cited, charged with or convicted of a felony or misdemeanor other than minor traffic violations, **regardless of the outcome**? *(This includes withheld judgments and matters that have been expunged.)*
☐	☐	8. Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice your medical profession with reasonable skill and safety? *(If you are receiving appropriate treatment that allows you to practice safely and without impairment, you may answer NO.)*

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 an athletic trainer.

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 an athletic trainer 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

VERIFICATION OF PROFESSIONAL EDUCATION

TO BE COMPLETED BY THE APPLICANT:

Full Name of Applicant:	
Address:	
Social Security Number:	**Date of Birth:**

_____

Applicant's Signature

TO BE COMPLETED BY REGISTRAR OR PROGRAM DIRECTOR: Please complete and return form directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0063. Express Mail: 11341 W. Chinden Blvd. Bldg 4, Boise, ID 83714; Fax: (208) 334-3536.

Major:	
Degree Received:	**Date of Degree:**

As an official of the school named, I certify that the person named above received a degree as noted after fulfilling all requirements.

(SEAL)

_____
Please type or print name of Registrar/Director

_____
Signature of Registrar/Director

_____
Name of School or Facility

_____
If changed, present name

_____
City **State** **Zip**

_____
Date of this Verification

DIRECTING PHYSICIAN REGISTRATION FORM

Approved By	Date Approved	Date Received

Athletic Trainer Name:

Address:

TO BE COMPLETED BY SUPERVISOR(S): Please complete and return form directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0063. Express Mail: 11341 W. Chinden Blvd. Bldg 4, Boise, ID 83714; or Fax: (208) 334-3536.

DIRECTING PHYSICIAN
Must be a currently licensed Idaho physician.

Name:

Address:

Telephone: **Idaho License No.:**

I certify that I have read the IDAPA Rules regarding Directing Physicians.

Signature _____

Date of Signature _____

ALTERNATE DIRECTING PHYSICIAN
Must be a currently licensed Idaho physician.

Name:

Address:

Telephone: **Idaho License No.:**

I certify that I have read the IDAPA Rules regarding Directing Physicians.

Signature _____

Date of Signature _____

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

Athletic Trainer Name:

Directing Physician's Name:

Alternate Directing Physician's Name(s):

Practice Site(s):

Type of Practice:

AFFIDAVIT

I, being first duly sworn, declare under penalty of perjury as follows: *(Please check the statement that applies)*

☐ I will be practicing as an athletic trainer in Idaho and meet the requirements listed below

☐ Prior to any practice as an athletic trainer in Idaho, I will meet the requirements listed below.

I will be practicing as an athletic trainer in Idaho and prior to any practice in Idaho, I will meet the requirements listed below.

I have completed the "Athletic Training Service Plan or Protocol" forms with my directing physician and have reviewed the agreement with my alternate directing physician.

A copy of the agreement is on file at each of my practice sites and is available to the Board upon request.

The agreement defines the working relationship and direction between my directing physician and me and includes: a list of the specific activities that will be performed by the athletic trainer; specific locations and facilities in which the athletic trainer will function; the methods to be used to insure responsible direction and control of the activities of the athletic trainer, which shall provide for: and on-site visit at least bi-annually and a periodic review of a representative sample of records. This review shall also include an evaluation of the quality of athletic training services being provided, the availability of the directing physician to the athletic trainer in person or by telephone, and procedures for providing backup for the athletic trainer in emergency situations, and procedures for addressing situations outside the scope of practice of the athletic trainer.

The written criteria were jointly developed by my directing physician, my alternate directing physician, and me. The agreement permits me to work under the direction of my directing physician(s).

Signature of Athletic Trainer _____

Date of Signature _____

Signature of Directing Physician _____

Date of Signature _____

Signature of Alternate Directing Physician _____

Date of Signature _____

State _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 20_____.

(SEAL)

Notary Signature _____

My commission expires _____

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

An Athletic Training Service Plan or Protocol is to be maintained at each practice site and available to the Board upon request. The Athletic Training Service Plan or Protocol is a written document mutually agreed upon and signed and dated the athletic trainer and directing physician that defines the working relationship and direction between the directing physician and the athletic trainer as specified by Board rule. The Board of Medicine may review the written Athletic Training Service Plan or Protocol, job descriptions, policy statements, or other documents that define the responsibilities of the athletic trainer in the practice setting and may require such changes as needed to achieve compliance with these rules, and to safeguard the public.

DO NOT SUBMIT YOUR ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL (SPOP1, PAGES 1-4) TO THE BOARD WITH YOUR APPLICATION FOR LICENSURE.

The following must be legible. Use additional sheets if necessary.

Athletic Trainer Name:

Directing Physician's Name:

Alternate Directing Physician's Name(s):

PRACTICE SITE(S):

Name of Facility/School/Organization:

Address:

Name of Facility/School/Organization:

Address:

Name of Facility/School/Organization:

Address:

Name of Facility/School/Organization:

Address:

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

Each licensed athletic trainer shall maintain a current copy of an Athletic Training Service Plan or Protocol between the athletic trainer and each of his or her directing physicians. This agreement shall **NOT** be sent to the Board but must be maintained on file at each location in which the athletic trainer is practicing. This agreement shall be made immediately available to the Board upon request and shall include:

ACTIVITIES

A listing of the general activities that will be performed by the athletic trainer. Check all that apply. (If checked, please list below anything in that section that is NOT part of your general activities.)

[ ] Prevention of athletic injuries by designing and implementing physical conditioning programs, performing preparticipation screenings, fitting protective equipment, designing and constructing protective products and continuously monitoring changes in the environment.

Comments:

[ ] Recognition and evaluation of athletic injuries by obtaining a history of the injury, individual inspection of the injured body part and associated structures and palpatation of bony landmarks and soft tissue structures. Immediate care of athletic injuries may require initiation of cardiopulmonary resuscitation, administration of basic or advanced first aid, removal of athletic equipment, immobilization, and transportation of the injured athlete. The athletic trainer will determine if the athlete may return to participation or, if the injury requires further definitive care, the athletic trainer will refer the injured athlete to the appropriate physician.

Comments:

[ ] Rehabilitation and reconditioning of athletic injuries by administering therapeutic exercise and physical modalities including cryotherapy, thermotherapy, and intermittent compression or mechanical devices. (Please list mechanical devices used.)

Comments:

[ ] Athletic training services administration includes implementing athletic training service plans or protocols, writing organizational policies and procedures, complying with governmental and institutional standards and maintaining records to document services rendered.

Comments:

[ ] Education of athletes to facilitate physical conditioning and reconditioning by designing and implementing appropriate programs to minimize the risk of injury.

Comments:

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

DIRECTION AND CONTROL

The methods to be used to ensure responsible direction and control of the activities to the athletic trainer that shall provide for an on-site visit at least bi-annually and availability of the directing physician to the athletic trainer in person or by telephone.

Please describe below how this will be accomplished at practice site(s):

_____

_____

_____

_____

_____

_____

_____

_____

_____

ATHLETIC TRAINING SERVICES REVIEW

Periodic review of a representative sample of records and a periodic review of the athletic training services being provided by the athletic trainer. This review shall also include an evaluation of adherence to the Athletic Training Service Plan or Protocol.

Please describe below how this will be accomplished at practice site(s):

_____

_____

_____

_____

_____

_____

_____

_____

ATHLETIC TRAINING SERVICE PLAN OR PROTOCOL

EMERGENCY PROCEDURES

Procedures for providing the availability of the directing physician to the athletic trainer in person or by telephone and procedures for providing direction to the athletic trainer in emergency situations.

Please describe below how this will be accomplished at practice site(s):

_____

_____

_____

_____

_____

ADDRESSING SITUATIONS OUTSIDE THE SCOPE OF PRACTICE

Procedures for addressing situations outside the scope of practice of the athletic trainer (e.g. substance abuse, eating disorders).

Please describe below how this will be accomplished at practice site(s):

_____

_____

_____

_____

_____

_____

_____

_____

Signatures:

Athletic Trainer _____

Date _____

Directing Physician _____

Date _____

Alternate Directing Physician _____

Date _____

SUPERVISOR AFFIDAVIT

TO BE COMPLETED BY THE APPLICANT:

*(This form is required for **provisional** athletic trainer licensure only.)*

Full Name of Applicant:

Address:

TO BE COMPLETED BY SUPERVISOR: Please complete and return form directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0063. Express Mail: 11341 W. Chinden Blvd. Bldg 4, Boise, ID 83714; or Fax: (208) 334-3536.

FACILITY

Name of Facility:

Address:

Telephone:

SUPERVISOR

Must be a currently licensed Idaho athletic trainer.

Name:

Address:

Telephone: **Idaho License No.:**

AFFIDAVIT OF SUPERVISOR

Applicant will work under my personal supervision, and I assume responsibility for the applicant's work.

(SEAL)

_____

Signature of Supervisor

State _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Signature _____

My commission expires _____

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 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: _____