DO NOT STAPLE

IDAHO STATE BOARD OF MEDICINE

P.O. Box 83720 • Boise ID 83720-0063 • (208) 327-7000

I hereby apply for registration as a:

MEDICAL RESIDENT – Fee $20 **MEDICAL RESIDENT WWAMI-** Fee $0

(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)*	
*Email Address		*Date of Birth *(Month/ Day/Year)*
*Telephone		Sex: Male Female

EDUCATION	ADDRESS	CITY/STATE/ZIP	DATES	DEGREE
MEDICAL SCHOOL			TO	MD or DO
POSTGRADUATE			TO	

Include with this form:

1) Copy of birth certificate or passport.
2) Name, address, and description of the course of study in Idaho. Please provide on a separate sheet.
3) For R-1 residents and interns prescription authority for Schedule III-V medications may be requested if such is integral to the training program. A statement to this effect from the program director is necessary in such cases.
4) Summary information regarding the following: Criminal charges or conviction (regardless of the outcome), medical disciplinary actions, malpractice actions, if any. Please provide details on a separate sheet and court documents.
5) Payment (if applicable) by personal check, cashier's check or Board of Medicine credit card transmittal form

Registration requested to begin ____.

Please Note: Registration will expire **June 30** of the following year. Registration can be renewed annually.

Applicant's Signature X	Date

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 Supervising Physician X		Signature of Alternate Supervising Physician X	
Name of Practice Site		Name of Practice Site	
Address	Date	Address	Date

Rev. 07/22

**Confidential-for Board Staff use only.*

IDAHO STATE BOARD OF MEDICINE
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(208) 327-7000

Fax (208) 334-3536
E-Mail info@bom.idaho.gov
Website bom.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: ____