OFFICE USE ONLY
Date received _____
Approved by _____
Date approved _____

DOPL-Idaho Board of Medicine
P.O. Box 83720
Boise, Idaho, 83720-0063

MEDICAL PERSONNEL
SUPERVISING PHYSICIAN REGISTRATION FORM

The Supervising Physician can designate one alternate supervising physician to oversee the medical personnel during the supervising physician's temporary absence. Please complete and return form to the Idaho State Board of Medicine at the address noted above.

MEDICAL PERSONNEL:

Medical Person's Name _____Idaho License #_____

Mailing Address _____
Street/PO Box, City, State, Zip

SUPERVISING PHYSICIAN:

Name _____Idaho License #_____

Business Address _____
Street/PO Box, City, State, Zip

Business Phone (___)_____ Other (___)_____ E-mail _____

NON-INCISIVE/NON-ABLATIVE PRESCRIPTIVE MEDICAL/COSMETIC DEVICE INFORMATION

Name of prescriptive device _____

Manufacturer _____

Device description _____

Intended device use _____

Hours of training on device use _____ Trainer Name / Affiliation _____

NON-INCISIVE/NON-ABLATIVE PRESCRIPTIVE MEDICAL/COSMETIC PRODUCT INFORMATION

Name of prescriptive product _____

Manufacturer _____

Product description _____

Intended product use _____

Hours of training on product use _____ Trainer Name / Affiliation _____

(continued)

MEDICAL PERSONNEL
SUPERVISING PHYSICIAN REGISTRATION FORM
(continued)

CERTIFICATION OF TRAINING OF MEDICAL PERSONNEL
PROVIDING EXCLUSIVELY NON-INCISIVE OR NON-ABLATIVE COSMETIC TREATMENTS

AFFIDAVIT

I certify that my responses attached are true and correct to the best of my knowledge and that I assume full responsibility for the exclusively non-incisive and non-ablative cosmetic treatments provided by the Medical Personnel named. I further certify that I have read and will comply with IDAPA 24.33.01, Rules of the Board of Medicine regarding Registration of Supervising Physicians.

_____
Supervising Physician signature Date

ALTERNATE SUPERVISING PHYSICIAN:

Name _____Idaho License #_____

Business Address _____
Street/PO Box, City, State, Zip

Business Phone (___)_____ Other (___)_____ E-mail _____

AFFIDAVIT

I certify that my responses attached are true and correct to the best of my knowledge and that I assume full responsibility for the exclusively non-incisive and non-ablative cosmetic treatments provided by the Medical Personnel named. I further certify that I have read and will comply with IDAPA 24.33.01, Rules of the Board of Medicine regarding Registration of Supervising Physicians.

_____
Alternate Supervising Physician signature Date

MEDICAL PERSONNEL:

I certify that the information contained in this form is an accurate description of the training I have received. I further certify that I have read and will comply with IDAPA 24.33.01, pertaining to the use of exclusively non-incisive and non-ablative prescriptive medical/cosmetic devices and products by medical personnel.

_____
Medical Personnel signature Date