DOPL - IDAHO BOARD OF MEDICINE

11341 W. Chinden Blvd., Building #4, Boise ID 83714 or

P.O. Box 83720, Boise ID 83720-0063

Phone: (208) 334-3233 Website: https://dopl.idaho.gov

E-mail: HP-Licensing@dopl.idaho.gov

REQUEST FOR OFFICIAL LICENSE/REGISTRATION VERIFICATION

Each state requires different forms of certification of licensure. Please check with the state where you are applying to see what is required before requesting certification from Idaho.

Primary source verifications can be obtained from Idaho by completing this form and returning by **mail or fax** with the required \$20.00 fee.

Form and payment maybe returned by fax to 208-334-3536 or mailed to: DOPL - Idaho Board of Medicine 11341 W. Chinden Blvd., Bldg 4, Boise, ID 83714 for processing.

License information can be viewed for free at https://apps-dopl.idaho.gov/IBOMPublic/LPRBrowser.aspx.

Physician & Surgeon (MD/DO) Physician Assistant Athletic Trainer Dietitian Respiratory Therapist/Polysomnographer Naturopathic Medical Do Requestor Name:	License Type:							
Requestor Name: E-mail: Address: Street/ PO Box City State Zip I hereby make request for an official certification of license/registration #	☐ Physician & Surgeon (MD/DO) ☐ Physician Assistant ☐					☐ Athletic Trainer		
Address: Phone number: Street/ PO Box City State Zip I hereby make request for an official certification of license/registration # Please mail or e-mail the certified document to: Name: Email: Address: Street/ PO Box City State Zip AFFIDAVIT I hereby certify that I am the holder of the license/registration noted above and that by signing this form I authorizing the Division of Occupational and Professional Licenses to certify to my licensure or registration and release of information that is not public record to the person or entity noted above.	☐ Dietitian ☐ Respiratory Therapist/Polysomnogra			/Polysomnographer		Naturopathic	Medical Doctor	
Address: Phone number: Street/ PO Box City State Zip I hereby make request for an official certification of license/registration # Please mail or e-mail the certified document to: Name: Email: Address: Street/ PO Box City State Zip AFFIDAVIT I hereby certify that I am the holder of the license/registration noted above and that by signing this form I authorizing the Division of Occupational and Professional Licenses to certify to my licensure or registration and release of information that is not public record to the person or entity noted above.	Requestor Name:			E-mail:				
Phone number: I hereby make request for an official certification of license/registration # Please mail or e-mail the certified document to: Name: Email: Address: Street/ PO Box City State Zip AFFIDAVIT I hereby certify that I am the holder of the license/registration noted above and that by signing this form I authorizing the Division of Occupational and Professional Licenses to certify to my licensure or registration and release of information that is not public record to the person or entity noted above.								
I hereby make request for an official certification of license/registration # Please mail or e-mail the certified document to: Name: Email: Address: Street/ PO Box City State Zip AFFIDAVIT I hereby certify that I am the holder of the license/registration noted above and that by signing this form I authorizing the Division of Occupational and Professional Licenses to certify to my licensure or registration and release of information that is not public record to the person or entity noted above.	Phone number:			·		State	Zip	
Address: Street/ PO Box City State Zip AFFIDAVIT I hereby certify that I am the holder of the license/registration noted above and that by signing this form I authorizing the Division of Occupational and Professional Licenses to certify to my licensure or registration and release of information that is not public record to the person or entity noted above.	Name:							
AFFIDAVIT I hereby certify that I am the holder of the license/registration noted above and that by signing this form I authorizing the Division of Occupational and Professional Licenses to certify to my licensure or registration and release of information that is not public record to the person or entity noted above.								
I hereby certify that I am the holder of the license/registration noted above and that by signing this form I authorizing the Division of Occupational and Professional Licenses to certify to my licensure or registrational release of information that is not public record to the person or entity noted above.	Street/ PO Box				City	State	Zip	
Cignoture	authorizing the Division of Occ	upational and Pr	se/reg	gistration noted above sional Licenses to cert	ify to	my licensure		



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:	scription of what and who	novment is for)
(Des	scription 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 Master	rCard Visa	
Expiration Date://////	/Y)	
I authorize the Idaho Board	of Medicine to charge the a	above credit card for a one-time
payment in the amount of \$		
Printed Name:		
Authorized Signature:		
Please Note: The Board of N	Medicine does not retain y	our credit card information.
If you would like to receive a	receipt of this transactior	n, provide your email address below.
Email Address:		