



State of Idaho
Division of Occupational and Professional Licenses
Idaho Board of Acupuncture

BRAD LITTLE
Governor
RUSSELL BARRON
Administrator

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

Interstate Mental or Behavioral Telehealth Registration Instructions

This application is for those who are actively licensed and in good standing in another state and wish to practice mental or behavioral virtual care in the State of Idaho at the level and within the practice scope for which they are actively licensed in another state.

"Virtual care" means technology-enabled health care services in which the patient and provider are not in the same location. Virtual care is an umbrella term that encompasses terms associated with a wide variety of synchronous and asynchronous care delivery modalities enabled by technology, such as telemedicine, telehealth, m-health, e-consults, e-visits, video visits, remote patient monitoring, and similar technologies. Virtual care is rendered at the physical location of the patient.

To qualify for registration, the applicant must fully complete the application, pay the required fee, and provide all requested information. Applications must include a valid social security number or other documentation as required under Idaho Code § 73-122. Incomplete applications (excluding those items that must be sent directly to our office from an issuing authority) will not be processed.

REGISTRATION FEE: \$35.00

FEES ARE NON-REFUNDABLE. Please make checks and money orders payable to the Division of Occupational and Professional Licenses/IDOPL. All returned checks are subject to a \$20.00 fee.

ATTENTION MEMBERS AND SPOUSES OF MEMBERS OF THE ARMED SERVICES:

If you are a member of the armed forces, an honorably discharged veteran or the spouse of an active member or veteran of the military, you may be entitled to expedited processing of your application. See Idaho Code § 67-9405. Additionally, active members of the military may be eligible for a waiver of the registration fee. See Idaho Code § 67-2606.

A.D.A. NOTICE: If you have a disability as defined under the Americans with Disabilities Act, and you require special accommodation regarding application, please attach a written request for special accommodation and current medical documentation identifying your disability and supporting the need for the requested accommodation.

Statutes and Rules governing the practice of mental or behavioral virtual care can be viewed at <https://dopl.idaho.gov>. Idaho Statutes and Rules are subject to change, and it is your responsibility to ensure you have read and understand the requirements to practice virtual care in Idaho. Please be sure to keep a copy of the application for your records. Registrations are non-transferable.

APPLICATION CHECKLIST:

License verification showing current, unrestricted licensure in all jurisdictions where you are currently or have been previously licensed which includes a discipline status field.

(The Division will attempt to obtain this information online. If this information is not available online, you will be notified. If required, license verification must be received directly from every state an applicant has held a license.)

Proof of Identification (a clear and readable color copy of a government-issued photo ID such as a passport, valid driver's license, or military ID).

If the name provided on this application does not match the name on the required documents, please provide a copy of proof of name change (i.e. marriage certificate, divorce decree or court order showing the transition of name).

If you have questions, please contact the relevant Idaho Board:

STATE BOARD OF COUNSELORS & MARRIAGE AND FAMILY THERAPISTS

Email address: cou@dopl.idaho.gov

STATE BOARD OF SOCIAL WORK EXAMINERS

Email address: swo@dopl.idaho.gov

STATE BOARD OF PSYCHOLOGIST EXAMINERS

Email address: psy@dopl.idaho.gov



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Interstate Mental or Behavioral Telehealth Registration Application

I hereby make application for a registration to practice as a mental or behavioral provider pursuant to the provisions of [Title 54, Chapter 57, Idaho Code](#), including Idaho Code§ 54-5714, and the applicable licensing authority's statutes and rules:

Select Telehealth Registration Type:

- Counselor Marriage or Family Therapist
 Social Worker Psychologist

Applicant Legal Name: _____

Address of Record: _____
(The above address is a public record.) Street/PO Box City State Zip

Mailing Address: _____
(Will be used as address of record if none provided above.) Street/PO Box City State Zip

Date of Birth: _____ **Social Security Number:** _____
(Required by Idaho Code§ 73-122)

Business Phone: _____ **Cell Phone:** _____

Applicant Email: _____

Have you been subject to any past or pending disciplinary proceedings against a license, excluding any action related to the non-payment of fees? () Yes () No

Are you or your spouse an active member or honorably discharged veteran of the United States Armed Services? () Yes () No

List all licenses you currently hold or have held as a mental or behavioral health provider in another state, territory, or locality?

State	License Number	Licensure Level	Is the license Active (yes / no)

AGREEMENT

I herein agree to each of the following statements:

- If I am granted a registration, I will only offer virtual health care services that are within the practice scope of my active out-of-state license, according to all applicable Idaho statute and rules, and in compliance with the Idaho community standard of care applicable. **Initials:** _____
- I consent to the jurisdiction of the State of Idaho, the Idaho Division of Occupational and Professional Licenses, and the applicable Idaho licensing authority. **Initials:** _____
- I will comply with any existing Idaho requirements regarding the maintenance of liability insurance. **Initials:** _____

CERTIFICATION

I hereby certify, to the best of my knowledge, the information on this application is true and correct. I further certify I have read the statutes and rules pertaining to mental or behavioral virtual care and the statutes and rules of the applicable licensing authority. I understand my registration may be suspended, revoked, or otherwise disciplined if it was obtained through false information or if I violate any applicable statutes or rules. I further understand the Division of Occupational and Professional Licenses may release information contained in licensing applications as required by law.

Signature of Applicant _____ **Date** _____