SUPERVISOR AFFIDAVIT

TO BE COMPLETED BY THE APPLICANT:

*(This form is required for **provisional** respiratory therapy 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; Fax: (208) 334-3536.

FACILITY

Must provide a Supervisor Affidavit to the Board for each facility Applicant is to practice respiratory care.

Name of Facility:

Address:

Telephone:

SUPERVISOR

Must be a currently licensed Idaho respiratory therapist or physician.

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 _____