State of Idaho
Division of Occupational and Professional Licenses
Idaho 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

Any person who qualifies as a bridge year physician, as defined in Idaho Code §54-1867, and pays the application fee required by the Board, may receive a limited license. Such license will be valid for a period of one year and shall be nonrenewable. Incomplete applications (excluding those items that must be sent directly to the Division of Occupational and Professional Licenses from an issuing authority) will not be processed.

"Bridge year physician" means a person who: is within the first year of graduation from a medical school accredited or provisionally accredited by an entity recognized by the board; is a United States citizen or attended medical school in the United States; and applied to, but was not accepted into, an accredited medical residency training program.

BRIDGE YEAR PHYSICIAN LICENSE FEE: $25

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.

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.

APPLICATION CHECKLIST FOR LICENSURE:

☐ Licensure Fee

☐ Proof of graduation from an accredited medical school – Transcripts with date conferred will need to be sent directly from the program to the Division of Occupational and Professional Licenses or emailed to hp-licensing@dopl.idaho.gov.

☐ Proof of U.S. citizenship (or attendance at a U.S. medical school)

☐ Proof of rejection from an accredited medical residency

☐ 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).

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BRIDGE YEAR PHYSICIAN APPLICATION

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)

Phone: _____ **Cell Phone:** _____

Applicant Email: _____

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

Please provide medical school information:

Program	Institution	Date of Graduation

I, _____ attest that all of the information contained herein is true, complete, and accurate to the best of my knowledge and belief. That I read and understand my scope of practice with this license. Should I furnish any false information, or cause any material omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license.

_____ _____
Signature **Date**

LICENSURE LIABILITY QUESTIONS

The Board recognizes the critical importance of physical and mental health and advocates proactive management of all health conditions to support the well-being of professional licensees and their patients. Our professionals experience trauma, whether directly or vicariously, which may lead to grief, depression, or other conditions. Ethical healthcare professionals will monitor their own personal well-being and attend to their own needs by seeking appropriate care to optimize their ability to care for others. Counseling and treatment provide important support for mental health and personal well-being. Therefore, nothing in the following attestation is intended to discourage those who might benefit from treatment or counseling from seeking it. Voluntarily seeking or receiving mental health treatment and counseling remains confidential and will not negatively impact your eligibility to obtain or retain a professional license.

Attestation:
As a healthcare professional, I commit to monitoring my personal health and well-being and, if I ever need treatment or counseling to support my health, I will attend to those needs by obtaining that treatment or counseling.

_____ _____

Signature **Date**

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1. Have you had an application for a professional license/registration denied or refused? If you have previously reported this information, you may select "No".

   ☐ Yes ☐ No

2. Have you been the subject of any proceeding by a licensing authority which either sought or resulted in censure, reprimand, probation, suspension, surrender, revocation, fine or other discipline/penalty in connection with any professional license/registration you held? If you have previously reported this information, you may select "No".

   ☐ Yes ☐ No

3. Have you ever had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited, or restricted? If you have previously reported this information, you may select "No".

   ☐ Yes ☐ No

4. Have you been arrested, charged, cited, indicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or withheld judgment? If you have previously reported this information, you may select "No".

   ☐ Yes ☐ No

5. Have you received a finding of guilt under the uniform code of military justice? If you have previously reported this information, you may select "No".

   ☐ Yes ☐ No

6. Have any judgments or settlements been paid on your behalf as a result of a professional liability or malpractice case(s)? If you have previously reported this information, you may select "No".

   ☐ Yes ☐ No

Unsafe behaviors resulting from habitual alcohol or substance use are grounds for formal discipline. However, the Division of Occupational and Professional Licenses believes that professionals who acknowledge their practice may be negatively impacted as a result of alcohol or substance use and who are actively engaged in recognized recovery methods do not represent a threat to the public and should be allowed to continue practicing in Idaho. In order to assure public safety, the Board supports monitoring of these professionals outside of the process of formal disciplinary investigations under provisions that assure support of recovery and prevention of return to use. The Idaho Health Professionals Recovery Program (HPRP) is an alternative to discipline program for licensed professionals with alcohol use or substance use disorders. For information about this Program, contact Katie Stuart, HPRP Administrator for the Division of Occupational and Professional Licenses, at (208) 577-2489 or Southworth Associates at (208) 323-9555 or toll free at (800) 386-1695.

7. I am currently enrolled as a participant in an alternative to discipline, diversion, peer assistance, or recovery program in another state and will need to transfer monitoring to Idaho. If you have previously reported this information, you may select "No".

   ☐ Yes ☐ No

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 bridge year physicians and understand my scope of practice to be under the supervision of a licensed physician or pursuant to a collaborative practice agreement, performing functions approved for physician assistants. I understand my license 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**_____