State of Idaho
Division Of Occupational and Professional Licenses
Board of Medicine

BRAD LITTLE
Governor
RUSSELL BARRON
Administrator

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Boise, ID 83720-0063
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MEDICAL RESIDENT APPLICATION - SUPERVISING PHYSICIAN FORM

MEDICAL RESIDENT

First Name	Middle Name	Last Name

Applicant's Signature X	Date

SUPERVISING PHYSICIAN

Statement of primary and alternate supervising physician:

The Medical Resident listed above will work under my personal supervision during the time period stated, and I assume responsibility for the applicant's work.

Name of Primary Supervising Physician *(Please Print)*		Name of Alternate Supervising Physician *(Please Print)*	
Signature of Supervising Physician **X**		**Signature of Alternate Supervising Physician** **X**	
Name of Practice Site		**Name of Practice Site**	
Address	**Date**	**Address**	**Date**

Rev. 01/26