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) 327-7000 Website: https://bom.idaho.gov
E-mail: BOM-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://elitepublic.bom.idaho.gov/IBOMPublic/LPRBrowser.aspx.

License Type:

☐ Physician & Surgeon (MD/DO) ☐ Physician Assistant ☐ Athletic Trainer

☐ Dietitian ☐ Respiratory Therapist/Polysomnographer ☐ Naturopathic Medical Doctor

Requestor Name: _____ E-mail: _____

Address: _____
Street/ PO Box City State Zip

Phone number: _____

I hereby make request for an official certification oflicense/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 am 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.

Signature: _____ Date: _____

IDAHO STATE BOARD OF MEDICINE
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Website bom.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: _____
(Description 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 ☐ MasterCard ☐ Visa

Expiration Date: _____ /_____
(MM) (YY)

I authorize the Idaho Board of Medicine to charge the above credit card for a one-time payment in the amount of $ _____ .

Printed Name: _____

Authorized Signature: _____

Please Note: The Board of Medicine does not retain your credit card information.

If you would like to receive a receipt of this transaction, provide your email address below.

Email Address: _____