STATE ATHLETIC COMMISSION
BUREAU OF OCCUPATIONAL LICENSES
700 WEST STATE STREET, PO BOX 83720
Boise, Idaho 83720-0063

APPLICATION FOR APPROVAL AS A RINGSIDE PHYSICIAN

Please complete this form by providing the requested information (please print). Your signature must be notarized and any supporting documentation must be attached. Submit the completed form to the address noted.

I hereby make application seeking Athletic Commission approval to serve as a Ringside Physician.

1. Full Name _____

2. Address of Record _____
(The above address is public record) Street City State Zip

3. Mailing Address_____
(The above address is not public record) Street/PO Box City State Zip

4. Date of Birth _____/_____/_____ **Place of Birth**_____ **Social Security No.** _____/_____/_____
mm dd yyyy

5. Business Phone (____)_____ **E-mail** _____
(The above phone number is public record)

6. My Idaho State Board of Medicine License Number is _____

7. Are you currently certified to perform cardiopulmonary resuscitation? ☐ **Yes** ☐ **No**
(If yes, please provide a copy of your current certification.)

AFFIDAVIT

I hereby certify that I am the person named above. I swear or affirm that the information provided on and attached to this application is true and accurate to the best of my knowledge and belief. I further certify that I have reviewed and will comply with the Idaho Laws and Rules governing the practice for which this application is being submitted.

_____ Signature of applicant

State of _____, County of _____, ss.
Subscribed and sworn before me this _____ day of _____, 20 _____.
(seal)

_____
Notary Public official signature
my commission expires_____

Commission's approval: Approved_____ Disapproved_____

Commissioner_____ Date:_____