

IDAHO MEDICAL ASSOCIATION  
 APPLICATION FOR ASSISTANT MEMBERSHIP  
 FOR PHYSICIAN ASSISTANTS  
 (Please print or type)

NAME OF APPLICANT \_\_\_\_\_ TITLE \_\_\_\_\_

PRACTICE NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_

OFFICE ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

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EDUCATION:  
 COLLEGE ATTENDED \_\_\_\_\_ YEAR GRADUATED \_\_\_\_\_

MASTERS DEGREE \_\_\_\_\_ YEAR GRADUATED \_\_\_\_\_

ACCREDITED TRAINING PROGRAM \_\_\_\_\_ YEAR GRADUATED \_\_\_\_\_

POST GRADUATE STUDY \_\_\_\_\_

YEAR FIRST LICENSED IN IDAHO \_\_\_\_\_

TYPE OF PRACTICE (SPECIALTY) \_\_\_\_\_

List in chronological order sites of previous practice beginning with most recent. Attach separate sheet if necessary.

Date	Practice Name	Supervising Physician	Reason for leaving

1. Have you ever been refused a professional registration? No\_\_\_\_ Yes \_\_\_\_\_
2. Have you ever failed a license/registration examination? No\_\_\_\_ Yes \_\_\_\_\_
3. Have you ever been convicted of a crime other than a non-felony motor vehicle violation? No\_\_\_\_ Yes \_\_\_\_\_
4. Have you ever been disciplined or reprimanded by any board or professional association in connection with practice act violation or unethical conduct? No\_\_\_\_ Yes \_\_\_\_\_

If the answer to any of the above questions is yes, please attach a letter giving full details of each.

IMA MEMBER WHO IS YOUR PRIMARY PHYSICIAN SUPERVISOR:

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

**As a member in good standing of the IMA, and supervisor of the above named Physician Assistant, I endorse his/her application for Assistant Membership in the Idaho Medical Association.**

Signature of Physician Supervisor \_\_\_\_\_ Date \_\_\_\_\_

**I apply for Assistant Membership in the Idaho Medical Association**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE RETURN TO THE IDAHO MEDICAL ASSOCIATION:  
P.O. BOX 2668, BOISE, ID 83701**