APPLICATION FOR REGISTRATION AS AN IDAHO FREE MEDICAL CLINIC

DIVISION OF PUBLIC HEALTH
IDAHO DEPARTMENT OF HEALTH AND WELFARE
450 WEST STATE STREET – 4TH FLOOR
P.O. BOX 83720
BOISE, IDAHO 83720-0036

Instructions: Please complete this entire application and submit it to the above address with a check in the amount of $50.00 made payable to the Bureau of Rural Health & Primary Care.

The undersigned hereby makes application for registration as a free medical clinic, subject to the provisions of the Idaho State Code and to the rules adopted by the Department of Health and Welfare.

SECTION I

A. Facility Name: _____

Organizational Official: _____

Sponsoring Organization (if applicable): _____

Sponsoring Officials/Board Members (if applicable):_____

_____

B. Facility Address:

_____

City:_____ Zip:_____ County:_____

Telephone Number:_____ E-Mail Address: _____

Hours of Operation: _____

C. Primary Medical Care Services provided: _____

_____

D. Describe the overarching purpose of the clinic: _____

_____

E. Describe the population the clinic is serving or intends to serve: _____

_____

SECTION II

The Organizational Official named above must initial each item and sign below.

_____ The free clinic shall maintain a list of health care providers associated with its provision of voluntary health care services. For each such health care provider, the free clinic shall maintain a copy of a current license, certificate or registration and shall further require each healthcare provider and to attest in writing that such provider's license, certificate or registration is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The free clinic shall maintain healthcare provider records for a period of at least five (5) years following the provision of healthcare services.

_____ The free clinic shall furnish healthcare provider records and additional information the department may require.

_____ I certify that this community-based program provides primary medical care without charge to individuals unable to pay.

_____ An informational conference call with the Department is required as part of the application process.

The information herein is true, complete, and correct to the best of my knowledge and belief.

Signature: _____

Title: _____

Date: _____

FOR OFFICIAL USE ONLY

A conference call was completed with Bureau of Rural Health & Primary Care

☐ Approved
☐ Disapproved (reason): _____

_____ _____
State Registrar Date

Idaho Bureau of Rural Health & Primary Care

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH