TEMPORARY LICENSE

Temporary licensure is an optional license available for applicants who have not previously passed the PANCE only.

Applicant's Name: _____

Name of Clinic: _____

Supervising Physician: _____ **License Number:** _____

Clinic Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number: _____ **Email:** _____

To be completed by the applicant:

I hereby certify that I will not practice until I have been granted a temporary license, and will cease practice upon the expiration of the license. Once the temporary license has been issued, I will only practice under the direct supervision of my supervising physician or substitute supervising physician as outlined in UCA 58-70a-306 (2)(c)

Signature of Applicant: _____ **Date** _____

To be completed by the supervising physician:

I certify that I am licensed in good standing and will provide direct supervision to the above named applicant as outlined in UCA 58-70a-306 (2)(c). I understand that I am responsible for their activities and services performed, and that once issued their temporary license to practice is valid for only 120 days. I understand that the applicant cannot work without a valid temporary license, either before it is issued or after it expires.

Signature of Supervisor: _____ Date: _____