SOUTH DAKOTA LICENSE RENEWAL APPLICATION

FOR OCCUPATIONAL THEREAPIST ASSISTANTS (OTA)

READ THOROUGHLY- THIS IS A NEW FORMAT. FILL COMPLETELY.
PLEASE PRINT LEGIBLY OR YOUR RENEWAL MAY NOT BE PROCESSED

Name:

Date of Birth:

Specialty or emphasis of practice:

Office Mailing Address: Street Address

City State Zip

Office Phone Office Fax:

Office Email:

Contact Person (if other than the applicant):

Home Mailing Address: Street Address

City State Zip

Home Phone Home Fax:

Home Email:

Preferred Mailing Address (license will be mailed to this address): No

CONTINUING EDUCATION STATEMENT:

I, , hereby state that I have completed the twelve (12) required hours of continuing education as required by South Dakota law. I am aware that the SDBMOE does not track CEUs for me. In the event that I am selected for an audit, I will provide proof within 10 days upon request.

I. HEALTH DISCLOSURE QUESTIONS:

IN THE PAST YEAR: (FOR ANY YES ANSWERS , ATTACH A SIGNED COMPLETE EXPLANATION)

a) Since your last renewal, have you been treated, hospitalized or confined for a Mental Health Issue, such as: Acute Stress Disorder, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder (recurrent or single episode), Alcoholism or Alcohol Abuse or Drug Use? **(If so, please provide letter from treating physician.)** No

b) To the best of your knowledge, information or belief, has any person or entity ever reported or suggested to you, or as a result of a self-evaluation, have you concluded, that your use of alcohol or drugs has affected your ability to provide appropriate care to patients or to otherwise perform the usual and necessary functions of your medical practice without posing a health risk to your patients? No

c) Are you currently using illegal drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

No

II. PROFESSIONAL QUESTIONS:

IN THE PAST YEAR: (FOR ANY YES ANSWERS, ATTACH A SIGNED COMPLETE EXPLANATION)

a) had your professional license terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished, or not renewed by any licensing board, any health-related entity, or agency organization? No

b) been subject to proceedings by a licensing agency to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, voluntarily or involuntarily relinquish, or not renew your professional license? No

c) been requested to appear, or appeared, before any licensure board concerning any violation by you of any law, rule or regulation of any state, district, territory or province of the United States, Canada, or other country? No

d) had your professional license or registration investigated, or is it currently being investigated, or have you been asked to appear before a licensing board or committee thereof? **If so, what were the results? (Attach explanation)** No

f) been subject to proceedings by any professional society to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, voluntarily or involuntarily relinquish, or not renew membership? No

g) been notified of a complaint by a medical facility, professional society or association, or any licensing agency? No

h) been dishonorably discharged from a branch of the U. S. military or National Guard? (If Not Applicable choose N/A) Not Applica

i) had your membership, participation, clinical privileges, or employment terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished or not renewed by any peer review organization, third party payor, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending? No

j) involuntarily relinquished your membership, participation, clinical privileges or request for privileges, employment, professional license or registration? No

k) had your membership or fellowship in any professional organization or medical society or your specialty board certification voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked? No

l) been reprimanded, censored, or otherwise disciplined by, or have you been subject to a corrective action agreement/plan with any licensing board, peer review organization, professional assistance program, third party payor, clinic, hospital, medical staff, or any health-related entity, or agency or organization? No

m) had your certificate or participation in any private, federal (i.e. Medicare, Medicaid, etc.), or state health insurance program terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished or not renewed, or is any investigation or proceeding with respect to any such action presently underway? No

n) been convicted or found guilty of a crime other than a minor traffic violation? No

o) been disciplined, found liable, guilty, or responsible for sexual impropriety, sexual harassment, disruptive behavior, or discriminatory behavior? No

p) had a report submitted to the National Practitioner Data Bank concerning your activities as a practitioner No

q) had any cases brought against you or received notice of intent to do so? No

r) had any judgments been entered against you in professional liability cases? No

s) have any final judgments or malpractice claims been paid by you? No

t) have any final judgments or settlements or malpractice claims been paid on your behalf by another entity? No

u) are there any malpractice challenges pending against you at this time? (Include any pending claims, lawsuits, judgments and/or settlements.) No

v) has any liability insurance carrier canceled your coverage? No

w) DO YOU CARRY MALPRACTICE OR LIABILITY INSURANCE (OR DOES YOUR FACILITY CARRY THIS FOR YOU)? No

If yes to previous question please answer the following

a) Insurance company name:

b) Policy Number(s):

c) Expiration Date(s):

d) Coverage:

1. Has your professional liability insurance carrier and/or the amount of coverage changed? No

2. Has your carrier excluded any specific procedures from your insurance coverage? No

3. Have you been denied coverage or been rated at a higher than average risk class for your specialty? No

AUTHORIZATION AND RELEASE

(READ CAREFULLY BEFORE SIGNING THIS SWORN STATEMENT)

Definitions:

Users: Any references to the terms "users" or "users of this application" in this Authorization shall include the following entities, but is not limited to the following entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners (SDBMOE) together with its board members, staff members, legal counsels, investigators, agents, employees, contractees, and authorized representatives;
2. Any other State or National licensing, reporting or regulatory board;
3. The Federation of State Medical Boards;
4. The National Practitioners Data Bank;
5. Any other South Dakota or United States agency, division or department;
6. Any hospital located within the State of South Dakota together with its board members, staff members, legal counsels, investigators and authorized representatives; and
7. Any medical facility located within the State of South Dakota together with its board members, staff members, legal counsels, investigators and authorized representatives.

I, , am the person described and identified herein. I have not engaged in any acts prohibited by the criminal or medical statutes of the State of South Dakota. I am the person named on any diploma or certificate which I have received, I am the lawful holder of said diploma or certificate, and the diploma or certificate was given to me in the regular course of instruction and examination without fraud or misrepresentation.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me, to furnish to the Users of this application, any such information, including documents, records regarding charges or complaints filed against me, formal, or informal, pending or closed, or any other pertinent data whether favorable or unfavorable and to permit the Users of this application to inspect and make copies of such documents, records, and other information in connection with this application for their evaluation of my professional, ethical, mental and physical qualifications.

The following apply to HIPAA authorization only:

I am aware of the Health Insurance Portability and Accountability Act of 1996 (hereinafter called HIPAA) and understand the provisions dealing with the privacy of my medical records. With such knowledge and understanding, I agree to the following:

a. I do hereby authorize the use or disclosure of my health information by the South Dakota Board of Medical and Osteopathic Examiners (SDBMOE), for purposes of obtaining a license to practice medicine in the state of South Dakota.

b. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and hospitals, and treatment for alcohol and drug abuse.

c. I understand that I have a right to revoke this HIPAA authorization at any time. I understand that if I revoke this HIPAA authorization I must do so in writing and present my written revocation to SDMBOE. I understand that the revocation will not apply to information that has already been released in response to this authorization.

d. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this HIPAA authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact SDMBOE for more information.

I further release, discharge and exonerate all such third parties from any and all claims, damages and liabilities whatsoever as a result of such third parties releasing the HIPAA information to the above-described entities and their authorized representatives.

The following does not apply to the HIPAA authorization above:

By applying for licensure, appointment, membership, and clinical privileges, I accept the following conditions and intend to be legally bound thereby.

1. I extend absolute immunity to, and release from any and all liability, and agree not to sue any User of this application for any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by the above or their authorized representatives relating to, but not limited to, the following:

   (a) matters regarding any license I now hold or have ever held;
   (b) applications for appointment or clinical privileges, including temporary privileges;
   (c) periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
   (d) proceedings for denial, suspension, or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;
   (e) summary suspensions;
   (f) hearings and appellate reviews;
   (g) hospital and medical staff quality assurance;
   (h) utilization reviews;
   (i) any other hospital, medical staff, department, service, or committee activities;
   (j) matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior;
   (k) any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of the hospital or health care facility; and
   (l) matters involving my membership in any professional society or as a provider for any third party payor or other health plan.

2. I further authorize all of the above described users and their authorized representatives to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical or mental condition, ethics, behavior, or any other matter bearing on my continuing qualifications for licensure, appointment to the medical staff, or membership in any third party payor, other health plan, or professional society. This authorization includes the right to inspect or obtain any and all documents, recommendations, reports, statements, or disclosures relating to such questions. I also expressly authorize said third parties to release the information to the above described Users, entities and their authorized representatives upon request. I further release, discharge and exonerate all such persons and entities from any and all claims, damages and liabilities whatsoever as a result of releasing such information, files or records requested by such users. I further release, discharge and exonerate all users as identified above from any and all claims, damages and liabilities whatsoever arising out of any request(s) made in the processing or consideration of this application. I further release, discharge and exonerate all users as identified above from any and all claims, damages and liabilities whatsoever as a result or such user providing any information to any user as contemplated and authorized by this authorization and release.

REGARDING DEADLINES AND LICENSE EXPIRATION:

Definitions:

Completed Renewal Materials: Any references to the terms "completed renewal materials" in this Document shall include the following:

1. South Dakota License Renewal Application, completely filled out with signed and attached explanations for any YES answers
2. Correct fee enclosed
3. Date and Original Signature

I, _____ hereby state that I am informed and understand the following deadlines and expirations:

By **15 JANUARY 2007,** my completed renewal materials must be received by the SDBMOE office to ensure receipt of my renewal or renewed license prior to the expiration of my current license. By this Document, I am informed that if my completed renewal materials reach the SDBMOE office after 15 JANUARY 2007, my renewal will be processed in the order received without priority, as I acknowledge that I will receive my renewed license as soon as practicable. I also acknowledge that it takes time to process my application and therefore, I understand that the sooner I send my application to the SDBMOE, the sooner I can anticipate it being processed and approved.

Further, I understand that in the event that my completed renewal items arrive or are postmarked after 28 FEBRUARY 2007, that my license automatically lapses and I shall discontinue practice or working in South Dakota until I reinstate and renew my license to active status.

I, the applicant for licensure with the South Dakota State Board of Medical and Osteopathic Examiners (SDBMOE), state that I am the applicant in the above application, that I have read the foregoing application and releases and know the contents thereof, and I unconditionally declare and affirm under the penalties of perjury that the statements made in this application been examined by me, and to the best of my knowledge and belief, are in all things true and correct. I further state that should I furnish any false information in this application, such act may constitute cause for the denial, suspension or revocation of any license issued to me by the South Dakota State Board of Medical and Osteopathic Examiners, and may cause the revocation of any clinical privileges, participation as a provider for any third party payor or other health care entity untilizing and relying upon this application or membership in any professional society.

(All Original Signatures in BLUE Ink Only)

Printed Name of Applicant: _____ Date _____

Applicant Signature (must be original): _____

Printed Name of Occupational Therapist **Supervisor** _____ Date _____

Occupational Therapist **Supervisor Signature (must be original)** _____

Additional Supervisors Sign on the back of this page in Blue Ink

I enclose the fee of **$50.00** for renewal of my South Dakota Permanent license **#** _____

(If License number is unknown then leave blank)

Make Check payable to: SDBMOE or complete below for credit card

Credit Card number: _____

Expiration Date: mm/yy _____

Signature _____ Date _____

Send Completed Renewal Materials to: 125 S. Main Ave.
Sioux Falls SD 57104