Renewal Instructions

1. Complete the application to the best of your abilities. Signature required in all designated spaces. An incomplete application will be rejected.

2. The "Required Disclosures" asks "yes/no" questions. If you answer "yes" to any of these questions, you shall provide a detailed explanation on separate stationary. Indicate the reason you answered yes, explain the circumstances, provide supporting documentation where appropriate, and sign and date the explanation.

3. Mail your renewal materials, including your method of payment, to:
   SDBMOE
   125 S. Main Ave
   Sioux Falls, SD 57104

4. If you need confirmation that your application has arrived in this office, use a mailing method with tracking capabilities. This office will NOT provide verification of mail arrival or receipt.

5. Please allow three (3) to four (4) weeks to receive an updated license/certificate/registration card. This will allow processing and mailing to the preferred mailing address that you have chosen.

6. The status of your licensure may always be viewed for free using "Online License Verification" at http://medicine.sd.gov.

7. If after six (6) weeks, you have not received a new wallet card, please contact the Board at http://medicine.sd.gov. Note: there is a $25 charge for replacing a license card once one has been mailed to the preferred mailing address that you have chosen.

Applicant Name: _____ Date: _____

Renewal Application for Physical Therapist Assistant Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during the **past year** you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name _____

First Name _____

Middle Name _____

Suffix _____

Maiden Name _____

_____
All other names used

2. Address/Phone: Please complete all sections and indicate which address you prefer to receive mail from the Board.

Preferred Address ◯ Practice ◯ Home

Practice Mailing Address

Street _____

City _____ State/Province _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

Home Address

Street _____

City _____ State/Province _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

Applicant Name: _____ Date: _____

3. Identification:

/ /		◯ M ◯ F	
Date of Birth (mm/dd/yyyy)	Birth City	Gender	Social Security Number

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a- 7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing discipline or as otherwise required by state or federal law.

4. Additional Information

1. My primary practice location is in this South Dakota county: _____

2. What is your specialty, emphasis or type of practice: _____

3. Are you currently practicing? Yes ☐ No ☐

4. Are you retired? Yes ☐ No ☐

If retired, what month and year did you retire? (mm/yyyy) _____

5. Supervision

These are my Physical Therapist supervisors:

1. Name: _____

2. Name: _____

3. Name: _____

4. Name: _____

5. Name: _____

☐ Check this box if you are not working and have no supervising PT.

Applicant Name: _____ Date: _____

ANSWER THE FOLLOWING QUESTIONS. **For any "YES" responses, please provide a complete, signed and dated explanation.**

Professional Questions: **In the past year... have you, your certificate or an application for certificate, whether formally or informally, whether voluntarily or involuntarily:**

1. been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, not renewed by, withdrawn or relinquished to any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization? Yes ___ No ___
2. been subject to proceedings or investigations by a licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization to terminate, stipulate, restrict, limit, withdraw condition, reprimand, suspend, revoke, refuse, deny, relinquish, or not renew your professional license? Yes ___ No ___
3. appeared or been requested to appear before any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization 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? Yes ___ No ___
4. been subject to proceedings or investigations (for any reason) by any medical facility or professional society, group, or organization to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, relinquish, withdraw or not renew membership? Yes ___ No ___
5. been notified of a complaint by a medical facility or professional society, group or organization, or any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization? Yes ___ No ___
6. been dishonorably discharged from a branch of the United States military or National Guard? Yes ___ No ___
7. had your membership, participation, clinical privileges, request for privileges or employment terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, withdrawn or relinquished to or not renewed by any peer review committee or organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization? Yes ___ No ___
   Is there a review pending? Yes ___ No ___
8. been reprimanded, censured or disciplined by, or been subject to a corrective action agreement/plan with any licensing or disciplinary board, agency or committee, health-related entity, governmental agency or organization, peer review organization, professional assistance program, third party payer, clinic, hospital, or medical staff? Yes ___ No ___
9. 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, relinquished, withdrawn or not renewed, or is any investigation or proceeding with respect to any such action presently underway? Yes ___ No ___
10. been charged by complaint, information, indictment, or otherwise, of any felony or misdemeanor, other than a minor traffic violation? Yes ___ No ___
11. plead guilty, or plead no contest to, any felony or misdemeanor, other than a minor traffic violation? Yes ___ No ___
12. been convicted of, or received a suspended imposition of sentence or suspended sentence of any kind, to a felony or misdemeanor, other than a minor traffic violation? Yes ___ No ___
13. been accused of or been disciplined, found liable, guilty, or responsible for sexual impropriety, sexual harassment, disruptive or discriminatory behavior? Yes ___ No ___
14. been reported to the NPDB (National Practitioners Data Bank) or HIPDB (Healthcare Integrity and Protection Data Bank) for any reason? Yes ___ No ___
15. had any cases, whether criminal, civil or administrative (of any kind or description), been brought against you or received notice of intent to do so? Yes ___ No ___

Applicant Name: _____ Date: _____

In the past year...have you, your certificate or an application for certificate, whether formally or informally, whether voluntarily or involuntarily:

16. had a change in your privileges at any hospital, clinic or health related agency? Yes ___ No ___

17. been contacted by a regulatory or licensing agency or any health related agency or organization that issued you a license for any reason? Yes ___ No ___

For questions 18 to 24, use Malpractice Liability Claims Information form (page 9) to explain yes answers.

18. had any judgements been entered against you in a professional liability cases? Yes ___ No ___
19. had any final judgments or malpractice claims paid by you? Yes ___ No ___
20. had any final judgments or settlements or malpractice claims been paid on your behalf by another entity? Yes ___ No ___
21. had any malpractice challenges pending against you at this time? (Including any pending claims, lawsuits, judgments, and/or settlements.) Yes ___ No ___
22. had any liability insurance carrier cancel your coverage? Yes ___ No ___
23. had been denied coverage or been rated at a higher than average risk class for your specialty? Yes ___ No ___
24. any specific procedures excluded from your insurance coverage by your carrier? Yes ___ No ___

Health Disclosure Questions.

1. Do you have a physical, mental or emotional condition which would preclude you from performing the essential functions of your practice? Yes ___ No ___

2. Have you ever been treated, hospitalized or confined for any Mental Health issue, including but not limited to: acute stress disorder, anxiety or mood disorder, bipolar disorder, major depressive disorder (recurrent or single episode), obsessive-compulsive disorder, alcoholism or alcohol abuse or drug use? (**If yes, please provide letter from treating physician along with your explanation**). Yes ___ No ___

3. 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 function of your practice without posing a health risk to your patients? Yes ___ No ___

4. Are you currently using illegal drugs or prescription controlled medications in an illegal manner? ("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. "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 Yes ___ No ___

5. Have you used illegal drugs within the last year? ("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 not include, however, the unlawful use of prescription controlled substances.) Yes ___ No ___

Applicant Name: _____ Date: _____

Required Fee

I enclose the fee of $50.00 for renewal of South Dakota license

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

Credit Card number: _____

Expiration Date: (mm/yyyy) _____

Print Name of person signing credit card: _____

Signature _____Date _____

REGARDING DEADLINES AND LICENSE EXPIRATION:
Definitions:
Completed Renewal Materials: Any references to the terms "completed renewal materials" in this Document shall include the following:

- South Dakota License Renewal Application: For any "YES" answer, please provide a complete, signed and dated explanation on separate stationary.
- Correct fee enclosed.
- Date and original signature.

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

By **December 1, 2008,** my completed renewal materials must be received and be reviewed 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 and acknowledge that if my completed renewal materials reach the SDBMOE office after December 1, 2008, my renewal will be processed in the order received without priority, and that I will receive my renewed certificate 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 January 1, 2009, that my certificate shall automatically expires and I shall discontinue practice or working in South Dakota until a review of my late application is completed. I understand that a late application is my responsibility and will not expect a speedy review nor will I harass Board staff or other government agencies prior to such a review. I understand I cannot work until my certificate is reviewed and renewed regardless of whether I have patients scheduled.

Applicant Name: _____ Date: _____

I am aware of the Health Insurance Portability and Accountability Act of 1996 (thereinafter called HIPAA) and understand the provisions dealing with the privacy of my medical records. With such knowledge an understanding, I agree to the following, **for purposes of South Dakota licensure matters only:**

a. I do hereby authorize the use or disclosure of my health information by the South Dakota Board of Medical & Osteopathic Examiners (SDBMOE), for purposes of licensure 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.

I further release, discharge and exonerate all third parties or person(s) from any and all claims, damages, and liabilities of any nature, who in good faith and without malice, release the HIPAA information to the SDBMOE for purposes of South Dakota licensure only.

Authorization and Release

Any references to the terms "Users" or "Users of this Application" in this authorization shall include the following entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners together with its board members, staff members, legal counsels, investigators, agents, employees, contractees, and authorized representatives hereinafter collectively referred to as SDBMOE;
2. Any other state or national medical licensing, medical reporting or medical regulatory board;
3. Any other South Dakota or United States agency in furtherance of and incompliance with SDBMOE's duties and responsibilities under my South Dakota Practices Act and its administrative regulations.

I am the person described 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 certificated that 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.

The following deals with SDBMOE consulting with and receiving information from third parties:

I authorize SDBMOE to consult with any third person or party who may have information or evidence concerning my professional, ethical, mental and physical qualifications, or any other matter that SDBMOE deems relevant regarding my continuing qualifications for licensure with SDBMOE. These third persons and parties include hospitals, institutions or organizations, my references, physicians, therapists, previous and present employers, past and present business and professional associates, and local, state, federal or foreign governmental agencies and instrumentalities, courts of any jurisdiction, associations, institutions or law enforcement agencies, together with their representatives thereof, who have custody or control of any documents, records, information or evidence that SDBMOE deems relevant to my Application. **I specifically authorize any state, federal or international law enforcement agency to conduct a background investigation and to report the findings thereof to the SDBMOE.**

Applicant Name: _____ Date: _____

I authorize such third persons and parties to unconditionally release to SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal, or informal, pending or closed, or any other pertinent data or evidence whether favorable or unfavorable that SDBMOE deems relevant to licensure, and to permit the SDBMOE to inspect, receive, and make copies of such documents, records, evidence, and other information for SDBMOE's evaluation of my professional, ethical, mental and physical qualifications that SDBMOE deems relevant to certification.

I release, discharge and exonerate from any and all claims, damages and liabilities whatsoever such third persons and parties, together with their authorized representatives, who in good faith and without malice, consult with and release to SDBMOE such information, evidence, files or records requested by SDBMOE that SDBMOE deems relevant to licensure.

***I declare and affirm under the penalties of perjury that**:*

This application for renewal of certificate, which includes all the information I have provided and the questions I have answered in the renewal application, have been examined by me, and to the best of my knowledge and belief, are in all things true and correct. I state unconditionally and without reservation that I absolutely understand each and every question contained in this application for certificate, and I have answered all of them completely and truthfully. If any user discovers any derogatory information regarding my personal background that was not disclosed when completing this application, the users may immediately cease all processing of this application, and I agree that such non-disclosure shall disqualify me for certification in South Dakota.

I understand and agree that my submission of this application and actions subsequent thereto, but prior to certification, shall bear directly upon my qualifications for certification, and I fully understand that the SDBMOE may consider all such actions in its determination whether to grant certification. To that end, I agree that any unprofessional or harassing behavior on my part, or on the part of any agent of mine, with the SDBMOE's members or staff shall establish grounds for the immediate cessation of all processing of this application and disqualify me for certification in South Dakota. A determination regarding derogatory information or of unprofessional or harassing behavior shall be the sole determination of the SDBMOE, and I will not assert that any other entity, judicial, or otherwise, may make such determination. I understand and agree that cessation of processing of this application by the users as a result of the acts of omissions by myself as described in this paragraph shall not require the SDBMOE or any other users of this application, to offer me a hearing or any other due process right, or any other statutory or constitutional rights, and that I will not assert that I am entitled to a hearing or any other due process rights, or any other statutory or constitutional rights that I may enjoy pursuant to SDCL 1-26, SDCL 36-4C, the South Dakota Constitution, or the United States Constitution. I hereby waive any and all due process rights and any other statutory or constitutional rights that I may enjoy as it relates to all matters described above and in any manner related to this application.

Print Applicant Name: _____ **Date:** _____

Applicant Signature: _____

6. Malpractice Liability Claims Information (use as needed and copy this form to report multiple claims)

Name of patient involved: _____

In which state did the action take place? _____ Case number (if applicable) _____

Which court? _____
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: _____

◯ Open (pending) ◯ Closed (settled) ◯ Dismissed (no money paid out) ◯ Other _____

Amount of judgement or settlement $ _____ Amount paid on your behalf $ _____

Month and year of event precipitating claim: _____

Month and year of lawsuit: _____

Insurance carrier at time: _____

What is/or was your status? ◯ Primary defendant ◯ Co-defendant ◯ Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event:
(Attach additional pages if necessary)

_____

Applicant Name: _____ Date: _____