SOUTH DAKOTA DEPARTMENT OF HEALTH

STATE BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

125 South Main Avenue Sioux Falls, SD 57104

*Complete form using BLUE Ink, if possible.

Date:_____

_____
Attn: Medical Staff Office

_____
_____

To Whom It May Concern:

The following physician has made application to the Board for a license to practice in the state of South Dakota:

_____ _____
Applicant's Name (Please Print) Dates Privileges Held

This doctor stipulates that he/she has held or currently holds hospital privileges at your facility. May we be furnished with the following information for which we thank you.

Did he/she have full privileges at your hospital? Yes No

Did he/she have restricted privileges at your hospital? Yes No

If yes, please explain: _____

_____

Derogatory Information:_____

Comments:_____

_____

(SEAL, if applicable)

_____
Signature

_____
Title

Mail Original form to the address above - DO NOT FAX