SOUTH DAKOTA LICENSE RENEWAL APPLICATION

FOR PHYSICIAN ASSISTANTS (PA)

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

Name:

Date of Birth:

Specialty or emphasis of practice:

Office Mailing Address: Facility Name

Street Address

City State Zip

Office Phone Office Fax:

Office Email

Optional 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):

CONTINUING EDUCATION STATEMENT:

I, , hereby state that I have the thirty (30) required hours of continuing education within the time period of 1 July 2006 through 30 June 2007 as required by South Dakota law. I am aware that the SDBMOE does not track Continuing Medical Education Credits (CMEs) 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.)

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?

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.)

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?

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?

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?

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)

e) 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?

f) been notified of a complaint by a medical facility, professional society or association, or any licensing agency?

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

h) 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?

i) involuntarily relinquished your membership, participation, clinical privileges or request for privileges, employment, professional license or registration?

j) 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?

k) 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?

l) 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?

m) had your dea registration terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished or not renewed?

n) been charged with, convicted of, or plead guilty to a felony or misdemeanor?

o) been disciplined, found liable, guilty, or responsible for sexual impropriety, sexual harassment, disruptive behavior, or discriminatory behavior?

p) had a report submitted to the National Practitioner Data Bank concerning your activities as a practitioner?

q) had any cases brought against you or received notice of intent to do so?

r) had any judgments been entered against you in professional liability cases?

s) have any final judgments or malpractice claims been paid by you?

t) have any final judgments or settlements or malpractice claims been paid on your behalf by another entity?

u) are there any malpractice challenges pending against you at this time? (Include any pending claims, lawsuits, judgments and/or settlements.)

v) has any liability insurance carrier canceled your coverage?

w) DO YOU CARRY MALPRACTICE OR LIABILITY INSURANCE (OR DOES YOUR FACILITY CARRY THIS FOR YOU)?

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?

2. Has your carrier excluded any specific procedures from your insurance coverage?

3. Have you been denied coverage or been rated at a higher than average risk class for your specialty?

AUTHORIZATION AND RELEASE

(PLEASE 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:

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 licensing, reporting or regulatory board;

3. The Federation of State Medical Boards;

4. Any other South Dakota or United States agency in furtherance of and in compliance with SDBMOE's duties and responsibilities under the laws of the state of South Dakota and its administrative regulations.

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 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 Renewal Application.

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 licensure.

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.

The following applies to HIPAA authorization only and may be refused by checking the box immediately following the HIPAA authorization:

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 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.

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 CFR164.524. 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 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.

OPTIONAL -- CHECKING THIS BOX WILL NOT DELAY THE RENEWAL PROCESS:

☐ **Check this box if you refuse to grant HIPAA Authorization to SDBMOE**

This page must have Original Signatures and Must be submitted with your Renewal Application. Sign in blue ink, if possible.

PHYSICIAN ASSISTANT PRACTICE AGREEMENTS

Primary Supervising Physicians Signature and Site of Practice Required

For _____

Circle

1. This Agreement is current and will be renewed for the coming year: Yes No

Primary Supervising Physician Printed Name: _____

Primary Supervising Physician Signature: _____

Facility Name for Physician Assistant: _____

If not renewing, the practice agreement will terminate effective (date) _____ for the following reason:

_____

2. This Agreement is current and will be renewed for the coming year: Yes No

Primary Supervising Physician Printed Name: _____

Primary Supervising Physician Signature: _____

Facility Name for Physician Assistant: _____

If not renewing, the practice agreement will terminate effective (date) _____ for the following reason:

_____

3. This Agreement is current and will be renewed for the coming year: Yes No

Primary Supervising Physician Printed Name: _____

Primary Supervising Physician Signature: _____

Facility Name for Physician Assistant: _____

If not renewing, the practice agreement will terminate effective (date) _____ for the following reason:

_____

4. This Agreement is current and will be renewed for the coming year: Yes No

Primary Supervising Physician Printed Name: _____

Primary Supervising Physician Signature: _____

Facility Name for Physician Assistant: _____

If not renewing, the practice agreement will terminate effective (date) _____ for the following reason:

_____

5. This Agreement is current and will be renewed for the coming year: Yes No

Primary Supervising Physician Printed Name: _____

Primary Supervising Physician Signature: _____

Facility Name for Physician Assistant: _____

If not renewing, the practice agreement will terminate effective (date) _____ for the following reason:

_____

Add Additional Sheets if Needed

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 JUNE 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 JUNE 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 15 JULY 2007, that my license automatically forfeits and I shall discontinue practice or working in South Dakota until I reinstate and renew my forfeited 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 shall constitute cause for the denial, suspension revocation, or disciplinary action 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: _____

Applicant Signature (must be original): _____ **Date** _____

I enclose the fee of **$100.00** 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 _____

By Signing above, I authorize a charge of $100.00 to the above credit card number.

Send Completed Renewal Materials to: 125 S. Main Ave.

Sioux Falls SD 57104