Verification of Professional Privileges and/or Employment – Page 1 of 2

(Copy this form as needed)

Have each facility where you worked and practiced complete this form and return it to this office. **PLEASE BE AWARE THAT THIS FORM MUST BE COMPLETED BY THE FACILITY WHERE YOU ACTUALLY PRACTICED NOT A CONTRACTING OR PLACEMENT AGENCY BECAUSE SOUTH DAKOTA REQUIRES PRIMARY SOURCE VERIFICATION.**

Therefore, this form shall be completed by all professional employers, clinics or hospitals.

To be completed by the applicant:

Dates of Employment: From: _____ To: _____
(MM/DD/YY) (MM/DD/YY)

Name of Current or Previous Facility: _____

Address of Current or Previous Facility: _____

_____

This is your authorization to release information regarding my privileges and/or employment in your files, favorable or otherwise, directly to: South Dakota Board of Medical and Osteopathic Examiners

_____
(Use BLUE INK: Applicant Signature and Date)

_____
(PRINT Applicant Name and Date)

Below filled out by Facility ONLY: (Please explain "YES" answers on a separate sheet)

1. Have you ever known of poor medical practice by this individual or have you discussed concerns about this individual's practice with medical staff officers or others? ☐ Yes ☐ No
2. Have there been reports of poor relationships between this individual and other members of the hospital staff, patients, or the public? ☐ Yes ☐ No
3. Are you aware of any derogatory information related to the individual's ability to practice medicine? ☐ Yes ☐ No
4. Are you aware of any mental, physical, emotional or personal problems this individual may have that might interfere with his/her practice of medicine? ☐ Yes ☐ No
5. Has this individual ever abused drugs or alcohol? ☐ Yes ☐ No
6. Has this individual ever shown any signs of chemical dependence? ☐ Yes ☐ No
7. Are you aware of any limitations, restrictions, or any other actions of any nature taken against the individual by a hospital, managed care entity, or any other health-related entity or organization, state or federal including medical academic institutions? ☐ Yes ☐ No
8. Does this individual accept hospital policies and function accordingly? ☐ Yes ☐ No
9. Has this individual ever taken a leave of absence or break from your facility for any reason and for any length of time? ☐ Yes ☐ No

Applicant Name: _____ Date: _____

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(Copy this form as needed)

Conditions under which employment ended (Voluntary or Other):

_____

_____

_____

If Other, explain:

_____

_____

_____

Derogatory Information, if any:

_____

_____

_____

Comments, if any:

_____

_____

_____

Signature:
(Signature Stamp Not Acceptable) _____

Print Name: _____

Direct Phone Number: _____

Title: _____

Date: _____

<u>DO NOT FAX – attach additional sheets if needed</u>
MAIL COMPLETED FORM TO:
SDBMOE
125 S. MAIN AVENUE
SIOUX FALLS, SD 57104