# Mailing List Order Form

Send by mail to:
SDBMOE
125 S. Main Ave
Sioux Falls, SD 57104

Send by Fax to:
605-367-7786
(ONLY IF PAYING BY CREDIT CARD)

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*Required Agreement:*

South Dakota Statutes provide that certain public records, which are not confidential or otherwise protected, are open to inspection and may be released or distributed for a reasonable fee provided that such records are not sold or redistributed by the recipient of such records. The undersigned states that this listing will not be used in derogation of these statutes..

Therefore I, being duly authorized to sign for the organization listed below, in consideration of receiving these records, do hereby unconditionally stipulate and agree that the undersigned organization, along with its officers, members, and representatives, will not sell, resell or redistribute the public record received from the South Dakota Board of Medical and Osteopathic Examiners (SDBMOE). The undersigned understands and acknowledges that a violation of this agreement is a crime under South Dakota law. Furthermore, the undersigned agrees to indemnify and hold the SDBMOE harmless from any claims made by any person against the SDBMOE as a result of the public records and lists so released under this agreement.

The South Dakota Board of Medical & Osteopathic Examiners does not release licensure database information to individuals/organizations performing credentialing or licensure verification services.

Your Signature: _____X Date_____

Print Name _____ Title _____

Organization _____

Mailing Address:

Street Address _____

Additional Address _____

City _____ State AL Zip Code _____

Phone Number _____ Email _____

Each list is $100.00. Please select the list(s) you would like and enter the total cost in the box below.

| | | | |
|---|---|---|---|
| ☐ Physician MD/DO | ☐ Physician Assistant | ☐ EMT - Paramedic | ☐ EMT - Intermediate |
| ☐ Physical Therapist | ☐ Physical Therapist Asst | ☐ Occupational Therapist | ☐ Occupational Therapy Assistant |
| ☐ Athletic Trainer | ☐ Dietitian / Nutritionist | ☐ Medical Assistant | ☐ Respiratory Therapist |

Total Cost _____ Credit Card # _____ Expire _____

Signature: _____X Date_____