For Board Use Only

Date of Application_____ App Fee $ _____ Check#_____

Date of NPTE Exam_____ Examination Results_____

License Number_____ Date Issued_____ Expires_____

Date Child Support Checked: _____ Date NPDB Checked:_____

DCI Results Received: _____ FBI Results Received:_____

South Dakota Board of Physical Therapy

810 N. Main St., #298 · Spearfish, SD 57783-2446 · Phone: (605) 642-1600

Please select type of License requested:

_____Physical Therapist ($120 application fee)

_____Physical Therapist Assistant ($120 application fee)

GENERAL INFORMATION (Please Type)

1. Name_____ 2. Degree_____
(Last) (First) (MI) (Previous or Maiden name)

Additional Name(s) or Alias_____

Social Security Number_____

3. Home Address_____
(Street or P.O. Box) (City) (State) (Zip)

Home Phone (_____) _____

Email Address: _____

4. Business Address_____
(Street or P.O. Box) (City) (State) (Zip)

Business Phone (_____) _____

5. Date of Birth _____/ _____/ _____ Place of Birth:_____

6. NPI Number: _____

7. FSBPT Number: _____

8. Gender: _____

9. Race (optional): _____

10. Ethnicity (optional) (Please Circle One): Hispanic - Nonhispanic

11. Are you or have you ever been licensed as a Physical Therapist or Physical Therapist Assistant any other State or Province? Please request a Verification of Licensure from each State or Province and have it returned directly to the Board Office.

State:_____ Licensure Type:_____

Issue Date_____ Expiration Date_____ License Number_____

State:_____ Licensure Type:_____

Issue Date_____ Expiration Date_____ License Number_____

State:_____ Licensure Type:_____

Issue Date_____ Expiration Date_____ License Number_____

State:_____ Licensure Type:_____

Issue Date_____ Expiration Date_____ License Number_____

12. Have you ever been licensed as a Physical Therapist or Physical Therapist Assistant in **South Dakota?**

Licensure Type_____ Licensure Number:_____

Issue Date_____ Expiration Date_____

Reason for Lapse or Termination:_____

13. Have you taken the NPTE Exam? Yes ❍ No ❍

If yes, you are responsible for contacting the Federation of State Boards of Physical Therapy (FSBPT) and having your score sent directly to this Board.

14. Date_____
15. Pass/Fail (if applicable) _____
16. If not, when will you take the exam?_____
17. If not, what state do you plan to take the exam? _____

ANSWERING YES TO ANY OF THE FOLLOWING QUESTIONS WILL NOT NECESSARILY DISQUALIFY YOU FROM OBTAINING A LICENSE. HOWEVER, PROVIDING FALSE OR MISLEADING ANSWERS WILL DISQUALIFY YOU FROM OBTAINING A LICENSE

18. Has any State/Province rejected your application or revoked your professional license or certificate? Yes ❍ No ❍

19. Has any professional association rejected your application for membership or revoked a membership you held? Yes ❍ No ❍
If yes, give complete details on a separate sheet.

20. Has any State/Province Regulatory Board or any professional organization determined that you committed unprofessional conduct? Yes ❍ No ❍
If yes, give complete details on a separate sheet.

21. Have you ever been convicted of a crime other than misdemeanor traffic offenses? Yes ❍ No ❍
If yes, give complete details on a separate sheet, including copies of the court's judgement and any written decisions in the case.

22. Have you ever been accused in a court of law of any civil or criminal misconduct, other than misdemeanor traffic offenses, which is not listed elsewhere in your responses to this application? Yes ❍ No ❍
If yes, give complete details on a separate sheet, including copies of the court's judgement and any written decision in that case.

23. Have you had charges dismissed or received a plea-bargain related to any crime? Yes ❍ No ❍
If yes, give complete details on a separate sheet.

24. Have you ever received charges of sexual discrimination or misconduct in the workplace? Yes ❍ No ❍
If yes, give complete details on a separate sheet.

25. Have you received treatment for addictions of any kind including those related to drugs or alcohol? Yes ❍ No ❍
If yes, give complete details on a separate sheet.

26. Have you received a mental health diagnosis that would prevent you from professional practice? Yes ❍ No ❍
If yes, give complete details on a separate sheet.

27. SDCL 25-7A-56 prohibits the issuance or renewal of any state regulated license if an applicant owes $1,000 or more In past due child support. Do you owe $1,000 or more in past due child support? Yes ❍ No ❍

28. Is your spouse an active duty member of the armed forces? Yes ❍ No ❍
If yes, was your spouse subject to military transfer to South Dakota? Yes ❍ No ❍
If yes, did you leave employment to accompany your spouse to South Dakota? Yes ❍ No ❍

29. EDUCATION OR TRAINING **Request official transcripts verifying graduation from accredited Physical Therapist or Physical Therapist Assistant Program to be sent directly to the Board office.**

University Or College	Address (City, State, Zip)	Dates Attended (xx/xx/xxxx – xx/xx/xxxx)	Degree	Major Subject
a.				
b.				
c.				
d.				
e.				

30. Was your education or training received outside the United States? Yes ❍ No ❍
If No, please proceed to question 31.
If yes, have you taken and passed the TOEFL Exam? Yes ❍ No ❍

EDUCATION OR TRAINING RECEIVED **OUTSIDE THE UNITED STATES**

University Or College	Address	Dates Attended (xx/xx/xxxx – xx/xx/xxxx)	Degree	Major Subject
a.				
b.				

31. PROFESSIONAL EXPERIENCE (Please list current position first)

Employer Name (current)_

Employer Address_____
(Street or P.O. Box) (City) (State) (Zip)

Phone Number:_____ Contact Name:_____

Position_____

Start Date:_____ End Date:_____

Employer Name:_____

Employer Address_____
(Street or P.O. Box) (City) (State) (Zip)

Phone Number:_____ Contact Name:_____

Position_____

Start Date:_____ End Date:_____

Employer Name:_____

Employer Address_____
(Street or P.O. Box) (City) (State) (Zip)

Phone Number:_____ Contact Name:_____

Position_____

Start Date:_____ End Date:_____

Employer Name:_____

Employer Address_____
(Street or P.O. Box) (City) (State) (Zip)

Phone Number:_____ Contact Name:_____

Position_____

Start Date:_____ End Date:_____

PLEASE READ CAREFULLY BEFORE YOU SIGN:
Affidavit and Authorization Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in the South Dakota license application process and documentation, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I will read and understand the South Dakota Board of Physical Therapy Application and will answer all questions during the application process and contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my application being denied and or being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the South Dakota Board of Physical Therapy any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the South Dakota Board of Physical Therapy or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the South Dakota Board of Physical Therapy, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the South Dakota Board of Physical Therapy.

I will immediately notify the South Dakota Board of Physical Therapy in writing of any changes including those changes to the answers to any of the questions contained in the application if such a change occurs at any time prior to licensure being granted to me.

I understand my failure to answer questions during the application process or questions contained in the application process truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice in South Dakota.

_____ _____
Applicant's Signature Date (mm/dd/yyyy)

_____
Please print name as you would like it to appear on license

AFFIDAVIT

State of_____

County of_____

The applicant_____, being duly sworn, declares all statements made in this application are true and correct to the best of his or her knowledge. Furthermore the applicant consents to a thorough investigation of present and past employment and other activities for the purpose of verifying qualifications for the license for which the application is made.

Subscribed and sworn before me this_____day of_____,_____

My commission expires_____

_____ Signature of Notary Public

Rev. 11/2023