SOUTH DAKOTA BOARD OF PODIATRY EXAMINERS

810 North Main Street • Suite 298 • Spearfish, SD 57783
(605) 642-1600

RELICENSURE APPLICATION

*****Please note: Renewal Fee is $350*****

Please Print or Type

Today's Date _____
Last Name _____
First Name _____
Lic#: _____
Social Security # _____
(Social Security Number's use is intended for purposes of identification related to licensure issues, discipline and other board related issues)

For Board Use ONLY

Date: _____ Ck #: _____

Child Support Checked: ❑ OK ❑ NOT OK

Corporation Renewal: Yes ❑ No ❑

Please complete Corporation Renewal and mail with your relicensure application.

I am not renewing _____. If not renewing, please complete the top portion and return this form to the board office. No additional notices will be sent to you.

Optional Fields: Date of Birth: _____ Gender: M _____ F _____

I prefer all correspondence be addressed to my: Home _____ Business _____

Home Address: _____
P.O. Box or Street City State Zip Code

Practice Name: _____ I am employed: Full Time _____ Part Time _____

Practice Address: _____
P.O. Box or Street City State Zip Code

Employing Facility: _____

Employing Address: _____
P.O. Box or Street City State Zip Code

Home Telephone (_____) _____ Work Telephone (_____) _____

Since the date of issuance or renewal of your SD Podiatry license

1.) Has this or any other state rejected your application or revoked your professional license or certificate? Yes ❑ No ❑
If yes, which state or states? _____ (Please attach explanation.)

2.) Has any professional association rejected your application for membership or revoked a membership you held? (If yes, attach explanation.) Yes ❑ No ❑

3.) Have you been found guilty of unprofessional conduct by a duly constituted professional organization or convicted by a state board of podiatry examiners of such unprofessional conduct? Yes ❑ No ❑
(If yes, give full details on a separate sheet.)

4.) Have you been convicted by a court of law for any offense in connection with your practice as a podiatrist? (If yes, attach explanation.) Yes ❑ No ❑

5.) Have you been convicted of a felony after being licensed in the State of South Dakota? Yes ❑ No ❑

6.) SDCL 25-7A-56 prohibits the issuance of 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 ❑

I, _____, (*please print*) hereby apply for licensure renewal by the State of South Dakota Board of Podiatry Examiners. Enclosed is the $150.00 renewal fee (*check or money order payable to the SD Board of Podiatry Examiners*). I understand that the fee is not refundable. I declare and affirm under penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

_____ _____
Signature Date

(over)

SOUTH DAKOTA BOARD OF PODIATRY EXAMINERS
CONTINUING EDUCATION REPORT FORM
20:55:01:08 Continuing education requirements:

Each licensee shall, prior to July 1, 2001, and every two years thereafter, provide written verification to the Board of Podiatry Examiners of the completion of 30 hours of continuing medical education. The program hours must be approved and certified by the Council of Podiatric Medical Education of the American Podiatric Medical Association. The necessary verification shall accompany each application for licensure renewal. If satisfactory verification is not received, the board shall deny the renewal application or take action to revoke or suspend the license of an individual not in compliance.

Up to 30 additional hours of satisfactory continuing medical education can be carried over for two years only.

It is your responsibility to retain in your records copies of any certificates you will be using for the applicable licensing period. You are responsible to provide the Board office verification of completion of the 30 hours of CEU's required by ARSD 20:55:01:08. The board office will not track the continuing education hours. If you have questions, please feel free to contact the Board office.

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TITLE OR NAME OF PROGRAM ____

HOURS APPROVED BY COUNCIL OF PODIATRIC MEDICAL EDUCATION ____________

____________ ____

DATE (S) OF PROGRAM ____

- -

TITLE OR NAME OF PROGRAM ____

HOURS APPROVED BY COUNCIL OF PODIATRIC MEDICAL EDUCATION ____________

____________ ____

DATE (S) OF PROGRAM ____

- -

TITLE OR NAME OF PROGRAM ____

HOURS APPROVED BY COUNCIL OF PODIATRIC MEDICAL EDUCATION ____________

____________ ____

DATE (S) OF PROGRAM ____

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I attest and affirm under penalties of perjury that I have received 30 hours of continuing education as required

by ARSD 20:55:01:08.____
Signature