

For Board Use Only

Date of Application _____ License Number _____

Date of Examination _____ Date Issues _____

Approved for Endorsement _____ Date Expires _____

\$ _____ Application Fee (\$500.00) CK# _____

Approving Board Member: _____

Application Not Approved: _____

**APPLICATION FOR THE
SOUTH DAKOTA BOARD OF PODIATRY EXAMINERS
810 North Main #298 Spearfish, SD 57783 (605) 642-1600**

Under the laws of the State of South Dakota, I hereby make application for a license as a Doctor of Podiatric Medicine.

Please type or print - -

Applicant's Name: _____
(Last) (First) (Initial) (Maiden)

Mailing Address: _____
(Street or P.O. Box) (City) (State) (Zip)

Home Telephone: (_____) _____

Date of Birth: _____ Social Security Number: _____

Email Address: _____

Race (please circle one): White Black or African American American Indian or Alaskan Native
Asian Native Hawaiian or Other Pacific Island Not Listed or Prefer Not to Answer Not Applicable

Gender (please circle one): Male Female Prefer Not to Answer Not Applicable

Ethnicity (please circle one): Hispanic Non-Hispanic Prefer Not to Answer Not Applicable

Employer Name: _____
(Firm Name) (Telephone Number)

(Street and P.O. Box if any) (City) (State) (Zip)
list both Street and P.O. Box

Employing Facility: _____
(Firm Name) (City) (State)

Employer Business Type: (please circle one): Unknown Individual Partnership Corporation
Association LLC LLP Other

I am employed: Full Time _____ Part Time _____

1. Are you licensed or have you ever been licensed to practice podiatric medicine in a state **other** than South Dakota? Yes No

Give State _____ Licensed from _____ to _____ Number _____

Give State _____ Licensed from _____ to _____ Number _____

If yes, please contact the board office(s) in the state(s) and request they submit a license verification on your past or current license. They will need to mail or email the verification **direct from their office** to the South Dakota Board of Podiatry Examiners at the address listed on the front page of this application or it may come by email to office@sdlicensing.com

2. Have you ever been licensed to practice podiatric medicine in South Dakota? Yes No
If yes, licensure # _____ from _____ to _____.

3. Has any state rejected your application or revoked/suspended your professional license?
 Yes No

If yes, give complete details on a separate sheet.

4. Has any State Board of Examiners determined that you committed unprofessional conduct?
 Yes No

If yes, give complete details on a separate sheet.

5. Have you ever been convicted, plead no contest/nolo contendere, plead guilty to, or been granted a deferred judgement or suspended imposition of sentence or had a prosecution deferred with respect to a felony? Yes No

6. Have you ever been convicted, plead no contest/nolo contendere, plead guilty to, or been granted a deferred judgment or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 misdemeanor traffic offense? *It is the applicant's responsibility to confirm whether the infraction is a class 1 or class 2 misdemeanor. Yes No

Please Note: *if you answered yes to 5 or 6, provide a personal statement detailing the nature of the crime, whether you think the crime relates to your practice, and description of rehabilitation efforts. You must also submit copies of charges or citations and ALL communications (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements. You must attach all communications for a violation to the signed and dated explanation of the violation. Please put correct correspondence in chronological order (most recent first). If you have more than one violation, please do the same for each violation. **This does not include records that have been sealed, expunged, or pardoned.***

7. 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

COLLEGE EDUCATION

Was your program a recognized school of Podiatry by the Council on Education of the American Podiatric Medical Association. Yes No Please have official undergraduate and doctoral college transcripts sent directly to the Board of Podiatry by the registrar of your College/University.

Name and Location of College/University (include advanced degrees and advanced study)	Dates Attended		Major Field	Degree Granted
	From	To		

POST GRADUATE TRAINING

This section applies only to applicants who graduate from podiatric college after July 1, 1995 (see SDCL 36-8-24).

Was your program approved by the Council of Podiatric Medical Education? Yes No Please list the location of your post graduate training.

Organization: _____ Dates: _____

Supervisor Name and License number: _____

Address: _____

Organization: _____ Dates: _____

Supervisor Name and License number: _____

Address: _____

EXAMINATIONS

1. Have you taken Parts I, II, and III of the American Podiatric Medical Licensing Examination (APMLE)? Yes No

(Please have a certified record of your scores sent directly to the board office from the examination board.)

REFERENCES

List two professional references who can attest to your competency as a Podiatrist. Please request each reference to send a letter to the Board of Podiatry Examiners.

1. Name: _____ Occupation: _____

Address: _____ Phone: _____

2. Name: _____ Occupation: _____

Address: _____ Phone: _____

BY APPLYING FOR LICENSURE TO THE SD BOARD OF PODIATRY EXAMINERS, I :

* Authorize Board representatives to consult with others who have been associated with me and/or who may have information regarding my competence and qualifications.

* Consent to Board representatives' inspection of all records and documents that may be material to an evaluation of my professional qualifications and competence to carry out the privileges I request, of my physical and mental health status and of my professional and ethical qualifications.

* Release from any liability all Board representatives for their acts performed in good faith and without malice in connection with evaluation of me and my credentials.

* Release from any liability all individuals and organizations who provide information, including otherwise privileged of confidential information, to the SD Board of Podiatry Examiners in good faith and without malice concerning my competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges.

The Board of Podiatry Examiners does adhere to the Human Relations Act of 1972 and therefore does not discriminate against applicants on the basis of race, sex, religion or national origin. In accordance with the American with Disabilities Act if you require special accommodations, please contact the board office for assistance.

APPLICANT SIGNATURE

PRINT NAME as you wish it to appear on license

DATE

NOTORIZATION

The applicant _____, having appeared before me and being identified as the same individual by the appropriate identification, being sworn, deposes and says that he/she is the person who executive this application; that the statements herein contained are true in every respect; that he/she has not suppressed any information that might affect this application.

Subscribed and sworn before me this _____ day of _____, _____

My commission expires _____

Signature of Notary Public

(Seal)