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 complete the Verification of Licensure in Other State form and send to the board office for each state you were licensed in. They will need to send the verification direct to the South Dakota Board of Podiatry.

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 subject to a jury or court finding of guilt (whether or not a judgment of guilt was ever entered)? ☐ Yes ☐ No

   If yes, give complete details on a separate sheet, including copies of the court's judgment and any written decisions in that case.

6. 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	Dates Attended		Major	Degree
	From	To	Field	Granted
(include advanced degrees and advanced study)				

* *

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:_____

* *

Application Revised 6/14

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.

_____

APPLICANT SIGNATURE

_____

Print name as it is to appear on license.

_____

Date

AFFIDAVIT

State of _____

SS

County of_____

The applicant _____ being duly sworn, declares that he or she is the person who is referred to in the foregoing application that the information supplied therein is true to the best of his or her knowledge, and that he or she has read and understands the application.

Subscribed and sworn to before me this _____

day of _____, _____.

_____

Signature

My commission expires _____

The Board of Podiatry Examiners does adhere to the Human Relations Act of 1972 an 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.

***NO APPLICATIONS WILL BE PROCESSED WITHOUT SUBMISSION OF ALL NECESSARY FEES.**
****Please follow the instruction/checklist sheet sent to you.**