SOUTH DAKOTA UNIFORM APPLICATION

INITIAL

Application is submitted by: _____

Name: _____
Last First Middle Suffix Title

For use by all practitioners including Allied Health Professionals.

Please note this is a universal application. Not all sections may apply to all practitioners.
Please mark all non-applicable sections with N/A.

Instructions
The initial credentialing application and attachments should be typed, legibly printed in black ink, or, preferably, electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application.

Checklist (please complete)

- ☐ Appropriate fees enclosed

Current copies of the following documents must be submitted with this application:

- ☐ All active licenses
- ☐ Drug Enforcement Administration Registration(s) with correct address(es) (if applicable)
- ☐ Current state controlled substance registration(s) (CSR)
- ☐ Current Board certification
- ☐ Curriculum Vitae
- ☐ Malpractice Litigation and Professional Complaints Form (if applicable)
- ☐ Current malpractice liability insurance documentation (as defined on Page 8)
- ☐ Your diploma and ECFMG certificate (if educated outside of U.S. or Canada)
- ☐ Current documentation of TB and Rubella immunity. (TB within the past 12 months.)

If all documents are not immediately available, please forward application and send remaining documents as soon as available.

In addition, please verify that you have:

- ☐ Provided complete street addresses wherever indicated, including past employment, hospital affiliations and references
- ☐ Designated dates by month, day and year time frames
- ☐ Explained all gaps in chronology (Page 6)
- ☐ Answered all of the Disclosure Questions on Pages 11 and 12 and enclosed explanations for affirmative answers
- ☐ Signed and dated the Authorization to Conduct Criminal Background Check (Page 10)
- ☐ Signed and dated the Affidavit, Release, Immunity and Authorization Statement (Page 13)
- ☐ Signed and dated the Affidavit (Page 14)

(PHOTO)

ENCLOSE WITH THIS APPLICATION A CURRENT PHOTOGRAPH OF YOURSELF.

Enter date taken on photograph (within the past 5 years) and sign in ink across the bottom.

This box to be completed by Allied Health Professionals Only

Profession/Title _____

Supervising/Collaborative Physician _____

All information must be printed in black ink, typed, or electronically generated!

PERSONAL DATA

Name: _____
Last First Middle Suffix Title

Maiden/Former/Other Name(s) _____ Spouse Name (optional): _____

Marital Status (optional): ☐ Married ☐ Single ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Date of Birth: ___/___/___ Birthplace (city/state/country): _____ U.S. Citizen: ☐ Yes ☐ No

Social Security Number: _____ UPIN or NPI: _____

Medicaid Number: _____ State _____ Medicare Number: _____ State _____

Current Home Address: _____
Street City/State/Country Zip Code

Local Home Address: _____
(if different from above) Street City/State/Country Zip Code

Preferred Mailing Address: ☐ Office ☐ Home E-mail address: _____

Pager / Mobile / Cell Number: _____ Home Phone Number: _____
(Please circle one)

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? ☐ Yes ☐ No

If yes, specify language(s): _____

PRIMARY PRACTICE LOCATION (REFER TO LIST OF SPECIALITIES ON PAGE 20 WHEN COMPLETING THIS SECTION)

Primary practice name: _____

Address: _____
Street City/State/Country Zip Code

Billing Address: _____
(if different from above) Street City/State/Country Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number: _____ E-mail Address: _____

Credentialing Contact: _____ Phone Number: _____

Expected Start Date: _____

Primary Specialty: _____ Subspecialty: _____

Specialty/Subspecialty in which care will be provided: _____

ADDITIONAL PRACTICE LOCATION(S) (REFER TO LIST OF SPECIALTIES ON PAGE 20 WHEN COMPLETING THIS SECTION)

Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Countrry Zip Code

Billing Address: _____
(if different from above) Street City/State/County Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary): _____

Credentialing Contact: _____ Phone Number: _____

Currently practicing at this location? ☐ Yes ☐ No Start Date: _____

If yes, will you continue to practice at this location? ☐ Yes ☐ No If no, last date of employment: _____

Primary Care or Specialty Care: _____

Specialty/Subspecialty in which care will be provided: _____

ADDITIONAL PRACTICE LOCATION(S) (Make additional copies of this page if necessary) (Refer to list of specialties on page 20 when completing this page.)

Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

Billing Address: _____
(if different from above) Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary) _____

Credentialing Contact: _____ Phone Number: _____

Currently practicing at this location? ☐ Yes ☐ No Start Date: _____

If yes, will you continue to practice at this location? ☐ Yes ☐ No If no, last date of employment: _____

Primary Care or Specialty Care: _____

Specialty/Subspecialty in which care will be provided: _____

ADDITIONAL PRACTICE LOCATION (Make additional copies of this page if necessary) (Refer to list of specialties on page 20 when completing this page.)

Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

Billing Address: _____
(if different from above) Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary) _____

Credentialing Contact: _____ Phone Number: _____

Currently practicing at this location? ☐ Yes ☐ No Start Date: _____

If yes, will you continue to practice at this location? ☐ Yes ☐ No If no, last date of employment: _____

Primary Care or Specialty Care: _____

Specialty/Subspecialty in which care will be provided: _____

ADDITIONAL PRACTICE LOCATION (Make additional copies of this page if necessary) (Refer to list of specialties on page 20 when completing this page.)

Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

Billing Address: _____
(if different from above) Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary) _____

Credentialing Contact: _____ Phone Number: _____

Currently practicing at this location? ☐ Yes ☐ No Start Date: _____

If yes, will you continue to practice at this location? ☐ Yes ☐ No If no, last date of employment: _____

Primary Care or Specialty Care: _____

Specialty/Subspecialty in which care will be provided: _____

MEDICAL/GRADUATE EDUCATION

From: __/__/____ Institution Name: _____

To: __/__/____ Degree and/or Certification Received: ☐MD ☐DO ☐DDS ☐DC ☐DPM ☐PhD ☐Other: _____

Address: _____
Street City/State/Country ZIP Code

Phone Number (if known): _____ Fax Number (if known): _____

From: __/__/____ Institution Name: _____

To: __/__/____ Degree and/or Certification Received: ☐MD ☐DO ☐DDS ☐DC ☐DPM ☐PhD ☐Other: _____

Address: _____
Street City/State/Country ZIP Code

Phone Number (if known): _____ Fax Number (if known): _____

ECFMG – APPLICABLE TO INTERNATIONAL MEDICAL GRADUATES

ECFMG Number: _____ Date Issued: _____ Valid Through: _____
(month/day/year) (month/day/year)

INTERNSHIP/POST-GRADUATE TRAINING (IF APPLICABLE)

From: __/__/____ Institution Name: _____

To: __/__/____ Internship Type/Specialty (transitional, rotating, 5th pathway, etc.): _____

Completed Training: ☐Yes ☐No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

RESIDENCY/POST-GRADUATE TRAINING

From: __/__/____ Institution Name: _____

To: __/__/____ Type of Program/Specialty: _____

Completed Training: ☐Yes ☐No If no, expected completion date: _____

List of procedures (to include volume of such) you have performed in your residency: (To be verified by Program Director / Department Chair) _____

_____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

RESIDENCY/POST-GRADUATE TRAINING - CONTINUED (If additional space is required, attach a separate sheet.)

From: __/__/__ Institution Name: _____

To: __/__/__ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

List of procedures (to include volume of such) you have performed in your residency: (To be verified by Program Director / Department Chair) _____

_____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

FELLOWSHIP/POST-GRADUATE TRAINING (If additional space is required, attach a separate sheet.)

From: __/__/__ Institution Name: _____

To: __/__/__ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

List of procedures (to include volume of such) you have performed in your fellowship: (To be verified by Program Director / Department Chair) _____

_____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

PROFESSIONAL AND ACADEMIC/FACULTY AFFILIATIONS

From: __/__/__ Institution Name: _____

To: __/__/__ Appointment Held/Position: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: __/__/__ Institution Name: _____

To: __/__/__ Appointment Held/Position: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: __/__/__ Institution Name: _____

To: __/__/__ Appointment Held/Position: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

CHRONOLOGICAL EMPLOYMENT/PRACTICE HISTORY

Chronological listing (month/day/year) of employment/practice history since completion of your post-graduate training. List all experience, including armed service and public health, time out of medical practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. LEAVE NO GAPS IN CHRONOLOGY. (If additional space is required, attach a separate sheet. Make as many copies of this page as needed to facilitate this disclosure.)

From: __/__/____ Organization Name/Activity: ______

To: __/__/____ Reason for Leaving: ______

Conditions under which you left ☐ Voluntary ☐ Other (explain) ______

Contact Name: ______ | Practice Still Open? ☐ Yes ☐ No | If no, attach sheet listing name, address and phone number of someone who can verify your time there.

Address: ______
Street City/State/Country Zip Code

Phone Number: ______

From: __/__/____ Organization Name/Activity: ______

To: __/__/____ Reason for Leaving: ______

Conditions under which you left ☐ Voluntary ☐ Other (explain) ______

Contact Name: ______ | Practice Still Open? ☐ Yes ☐ No | If no, attach sheet listing name, address and phone number of someone who can verify your time there.

Address: ______
Street City/State/Country Zip Code

Phone Number: ______

From: __/__/____ Organization Name/Activity: ______

To: __/__/____ Reason for Leaving: ______

Conditions under which you left ☐ Voluntary ☐ Other (explain) ______

Contact Name: ______ | Practice Still Open? ☐ Yes ☐ No | If no, attach sheet listing name, address and phone number of someone who can verify your time there.

Address: ______
Street City/State/Country Zip Code

Phone Number: ______

From: __/__/____ Organization Name/Activity: ______

To: __/__/____ Reason for Leaving: ______

Conditions under which you left ☐ Voluntary ☐ Other (explain) ______

Contact Name: ______ | Practice Still Open? ☐ Yes ☐ No | If no, attach sheet listing name, address and phone number of someone who can verify your time there.

Address: ______
Street City/State/Country Zip Code

Phone Number: ______

Explain any gaps/interruptions of medical/professional practice (if additional space is required, attach a separate sheet):

From: __/__/____ Explain: ______

To: __/__/____ ______

______

From: __/__/____ Explain: ______

To: __/__/____ ______

______

Primary Hospital Affiliation

If no hospital privileges, describe method/coverage for continuity of care. Please provide physician's name, if applicable.

____

____

From: ___/___/___ Facility Name: ______________________

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): ______________________

Department Name: ______________________

Department Chairperson or Chief of Staff: ______________________

Address: ______________________
Street City/State/Country Zip Code

Phone Number (if known): ______________________ Fax Number (if known): ______________________

Other Hospital Affiliations – Present and past affiliations beginning with most recent.

(Additional space is provided on the Hospital Affiliation Addendum, Page 18. You may make extra copies of Page 18 or attach a separate sheet for additional affiliations.)

From: ___/___/___ Facility Name: ______________________

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): ______________________

Department Name: ______________________

Department Chairperson or Chief of Staff: ______________________

Address: ______________________
Street City/State/Country Zip Code

Phone Number (if known): ______________________ Fax Number (if known): ______________________

From: ___/___/___ Facility Name: ______________________

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): ______________________

Department Name: ______________________

Department Chairperson or Chief of Staff: ______________________

Address: ______________________
Street City/State/Country Zip Code

Phone Number (if known): ______________________ Fax Number (if known): ______________________

From: ___/___/___ Facility Name: ______________________

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): ______________________

Department Name: ______________________

Department Chairperson or Chief of Staff: ______________________

Address: ______________________
Street City/State/Country Zip Code

Phone Number (if known): ______________________ Fax Number (if known): ______________________

SPECIALTY/SUBSPECIALTY CERTIFICATION (REFER TO LIST OF SPECIALTIES ON PAGE 20 WHEN COMPLETING THIS SECTION)

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Expiration Date

If not certified, please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failures of written or oral exams, if any. _____

_____

LICENSURE – List all past and current professional licenses. (If additional space is required, attach a separate sheet.)

State	License Number	Date Issued	Expiration Date	License Status
		/ /	/ /	☐ Active ☐ Inactive
		/ /	/ /	☐ Active ☐ Inactive
		/ /	/ /	☐ Active ☐ Inactive
		/ /	/ /	☐ Active ☐ Inactive
		/ /	/ /	☐ Active ☐ Inactive
		/ /	/ /	☐ Active ☐ Inactive
		/ /	/ /	☐ Active ☐ Inactive
		/ /	/ /	☐ Active ☐ Inactive
		/ /	/ /	☐ Active ☐ Inactive
		/ /	/ /	☐ Active ☐ Inactive

DRUG ENFORCEMENT ADMINISTRATION REGISTRATION (If additional space is required, attach a separate sheet.)

DEA Number: _____ State: _____ Expiration Date: / /

Approved for all schedules? ☐ Yes ☐ No, please explain _____

If you do not maintain a DEA certificate, please explain:

☐ Not applicable to practice. ☐ DEA certificate pending. Date application submitted to DEA: / /

☐ Other _____

STATE CONTROLLED SUBSTANCE CERTIFICATION/REGISTRATION (If applicable – not applicable to AZ, FL, MN, WI).

Issued by: _____ Number: _____ Expiration Date: / /

LIABILITY INSURANCE – INSURANCE CARRIER FOR PRIMARY PRACTICE LOCATION (10-year history)

Enclose a copy of professional liability insurance coverage (e.g., face sheet/verification of self-insurance) for primary practice location to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered. If additional space is required, attach a separate sheet.

COVERAGE DATES:

From: / / Insurance Carrier Name: _____

To: / / Address: _____
Street City/State/Country Zip Code

Name in which policy issued: _____

Policy number: _____ Expiration Date: / /

Amount of coverage (per occurrence/aggregate): _____

Liability Insurance - Continued

From: ___/___/___ Insurance Carrier Name: ______________________________

To: ___/___/___ Address: ______________________________

Street City/State/Country Zip Code

Name in which policy issued: ______________________________

Policy number: ______________________ Expiration Date: ___/___/___

Amount of coverage (per occurrence/aggregate): ______________________

From: ___/___/___ Insurance Carrier Name: ______________________________

To: ___/___/___ Address: ______________________________

Street City/State/Country Zip Code

Name in which policy issued: ______________________________

Policy number: ______________________ Expiration Date: ___/___/___

Amount of coverage (per occurrence/aggregate): ______________________

From: ___/___/___ Insurance Carrier Name: ______________________________

To: ___/___/___ Address: ______________________________

Street City/State/Country Zip Code

Name in which policy issued: ______________________________

Policy number: ______________________ Expiration Date: ___/___/___

Amount of coverage (per occurrence/aggregate): ______________________

From: ___/___/___ Insurance Carrier Name: ______________________________

To: ___/___/___ Address: ______________________________

Street City/State/Country Zip Code

Name in which policy issued: ______________________________

Policy number: ______________________ Expiration Date: ___/___/___

Amount of coverage (per occurrence/aggregate): ______________________

Professional/Peer References

List three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgment, professional performance, and clinical competence or have been responsible for professional observation of your work. A peer is defined as an individual in the same professional discipline with essentially equal qualifications (MD and DO are considered equivalent; DDS/DMD for DDS/DMD; PhD for PhD, Allied Health Professionals/Supervisor or Physician, etc.) **Limit to one (1) current office associate. Do not include your residency director, fellowship director, relatives, or pending partners.** At least one reference should be in your specialty (and if possible from the same subspecialty). Provide current and complete addresses. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

Name: ______________________ Title: ______________________

Relationship to Applicant: ______________________________

Facility Name: ______________________________

Address: ______________________________

Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

Professional/Peer References - Continued

Name: _____ Title: _____

Relationship to Applicant: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

Name: _____ Title: _____

Relationship to Applicant: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

Authorization to Conduct Criminal Background Check and Release

Definitions:
Users: Any references to the terms "users" or "users of this application" in this Affidavit shall include the following entities, but is not limited to the following persons and entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners;
2. Any other Board of Medicine;
3. Any other state or federal agency;
4. Any hospital;
5. Any clinic;
6. Any medical society;
7. Any third party payor, health insurer, or any other health care benefit plan;
8. Any person or entity processing this application;
9. Any person or entity which ever utilizes, relies on, or processes this application;
10. Any individual or entity providing any information about my personal or professional background, or my ethical, physical or mental qualifications to practice, or obtain licensure, or any other status as applied for in this application;
11. Any other person or entity which may ever be involved in any respect with this application; and
12. Any and all agents, employees, and authorized representatives of any of the above persons or entities.

I, _____, hereby authorize all users of this application, to request and receive any information and records concerning me, including but not limited to consumer credit, criminal record history, worker's comp., driving, employment, military, civil and educational data and reports, from any individuals, corporations, partnerships, associations, institutions, schools, governmental agencies and departments, courts, law enforcement and licensing agencies, consumer reporting agencies and any other entities, including my present and previous employers.

I further release and discharge the users and all of their agents and all their subsidiaries and affiliates, and every employee or agent of any of them, and all individuals and personal, business, private or public entities of any kind, from any and all claims and liability arising out of any request(s) made in the processing or consideration of this application. I also authorize the procurement of any investigative consumer report and understand that it may contain information about my character, general reputation, personal characteristics, and mode of living, whichever are applicable. I further understand that reporting of information pursuant to the Fair Credit Reporting Act is not intended to authorize or condone a prospective employer's request for and reliance upon information for purposes which are not legitimate under the Fair Credit Reporting Act or any federal or state employment laws. I acknowledge that I have voluntarily provided the above information for licensure, employment, and other purposes, and I have carefully read and I understand this authorization.

I further release all users from any and all claims, damages and liabilities whatsoever as a result of such user providing any information to any user as contemplated and authorized by this authorization and release.

This authorization and release shall constitute my stand-alone, consumer notification that a report will be requested and used for the purpose of evaluating me for licensure, employment, promotion, reassignment or retention as an employee, and other purposes. The following is my true and complete legal name and all information is true and correct to the best of my knowledge.

_____ _____
Signature Date

Disclosure Questions for Initial Credentialing

Please provide a complete explanation if any of the following questions are answered in the affirmative. Use a separate sheet to continue, if necessary.

1. ☐ Yes ☐ No Has your professional license or registration ever been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished, or not renewed by any licensing board or any health-related entity, or agency organization, or is there a review pending?

2. ☐ Yes ☐ No Have you ever been subject to proceedings by a licensing agency to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, voluntarily or involuntarily relinquish, or not renew a medical license?

3. ☐ Yes ☐ No Have you ever been requested to appear, or appeared, before any licensure board concerning any violation by you of any law, rule or regulation of any state, district, territory or province of the United States or Canada?

4. ☐ Yes ☐ No Has your professional license or registration ever been or is it currently being investigated, or have you ever been asked to appear before a licensing board or committee thereof? If so, what were the results?

5. ☐ Yes ☐ No Has your DEA registration ever been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished or not renewed, or is there a review pending?

6. ☐ Yes ☐ No Have you ever been subject to proceedings by a professional society to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, voluntarily or involuntarily relinquish, or not renew membership?

7. ☐ Yes ☐ No Have you ever been notified of a complaint by a medical facility, professional society or association, or any licensing agency?

8. ☐ Yes ☐ No Have you ever been terminated, asked to resign or resigned, or otherwise not completed any post-graduate, residency, or fellowship training program?

9. ☐ Yes ☐ No Has your membership, participation, clinical privileges, or employment ever been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished or not renewed by any peer review organization, third party payor, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

10. ☐ Yes ☐ No Have you ever served in the military, and, if so, if your discharge was anything other than an “honorable” discharge, please explain in detail.

11. ☐ Yes ☐ No Have you ever voluntarily relinquished your membership, participation, or clinical privileges or voluntarily withdrawn a request for privileges, employment, professional license, or registration to avoid disciplinary action, or prior to or during an investigation into your conduct or competency?

12. ☐ Yes ☐ No Have you ever involuntarily relinquished your membership, participation, clinical privileges or request for privileges, employment, professional license or registration?

13. ☐ Yes ☐ No Has your membership or fellowship in any professional organization or medical society or your specialty board certification ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

14. ☐ Yes ☐ No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing board, peer review organization, professional assistance program, third party payor, clinic, hospital, medical staff, or any health-related entity, or agency or organization?

15. ☐ Yes ☐ No Has your certificate or participation in any private, federal (i.e. Medicare, Medicaid, etc.), or state health insurance program ever been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished or not renewed, or is any investigation or proceeding with respect to any such action presently underway?

16. ☐ Yes ☐ No Are you currently charged with, aware of pending charges, or been found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), fraud, DWI, crime involving the practice of medicine, a crime involving moral turpitude, or other offense?

17. ☐ Yes ☐ No Have you ever been disciplined, found liable, guilty, or responsible for sexual impropriety, sexual harassment, disruptive behavior, or discriminatory behavior?

18. ☐ Yes ☐ No Have you ever had any professional liability claims or lawsuits brought against you, or do you have claims or lawsuits now pending, or have settlements or final judgments been rendered against you? If yes, please complete the enclosed Malpractice Litigation Addendum. You may be asked for additional information by individual organizations.

19. ☐ Yes ☐ No Has any professional liability carrier ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?

AFFIDAVIT, RELEASE, IMMUNITY AND AUTHORIZATION

(PLEASE READ CAREFULLY BEFORE SIGNING THIS SWORN STATEMENT)

Definitions:
Users: Any references to the terms "users" or "users of this application" in this Affidavit shall include the following entities, but is not limited to the following entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners;
2. Any other Board of Medicine;
3. Any other state or federal agency;
4. Any hospital;
5. Any clinic;
6. Any medical society;
7. Any third party payor, health insurer, or any other health care benefit plan;
8. Any person or entity processing this application;
9. Any person or entity which ever utilizes, relies on, or processes this application;
10. Any individual or entity providing any information about my personal or professional background, or my ethical, physical or mental qualifications to practice, or obtain licensure, or any other status as applied for in this application;
11. Any other person or entity which may ever be involved in any respect with this application; and
12. Any and all agents, employees, and authorized representatives of any of the above persons or entities.

I, _____, being first duly sworn depose and say that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of the State of South Dakota; that I am the person named on any diploma or certificate which I have received; that I am the lawful holder of said diploma or certificate; that said diploma or certificate was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to all users of this application any information, files or records required by the users of this application for their evaluation of my professional, ethical and physical qualifications.

By applying for licensure, appointment, membership, and clinical privileges, I accept the following conditions and intend to be legally bound thereby.

1. I extend absolute immunity to, and release from any and all liability, and agree not to sue any user of this application for any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by the above or their authorized representatives relating to, but not limited to, the following:

(a) matters regarding any license I now hold or have ever held;
(b) applications for appointment or clinical privileges, including temporary privileges;
(c) periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
(d) proceedings for denial, suspension, or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;
(e) summary suspensions;
(f) hearings and appellate reviews;
(g) hospital and medical staff quality assurance;
(h) utilization reviews;
(i) any other hospital, medical staff, department, service, or committee activities;
(j) matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior;
(k) any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of the Hospital or any other hospital or health care facility; and
(l) matters involving my membership in any professional society or as a provider for any third party payor or other health plan.

I further release all such third parties from any and all claims, damages and liabilities whatsoever as a result of such third parties releasing the information to the above-described entities and their authorized representatives.

2. I further authorize the above described entities (users) and their authorized representatives to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter bearing on my qualifications for licensure, appointment to the medical staff, or membership in any third party payor, other health plan, or professional society. This authorization includes the right to inspect or obtain any and all documents, recommendations, reports, statements, or disclosures relating to such questions. I also expressly authorize said third parties to release the information to the above described entities and their authorized representatives upon request.

I further release all such persons and entities from any and all claims, damages and liabilities whatsoever as a result of releasing such information, files or records requested by such users.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I

furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery in the State of South Dakota, or clinical privileges, participation as a provider for any third party payor or other health care entity utilizing and relying upon this application or membership in any professional society.

Signature of Applicant _____

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

Notary Public _____

(Seal)

My Commission expires: _____

AFFIDAVIT

(PLEASE READ CAREFULLY BEFORE SIGNING THIS SWORN STATEMENT)

Definitions:
Users: Any references to the terms "users" or "users of this application" in this Affidavit shall include the following entities, but is not limited to the following entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners;
2. Any other Board of Medicine;
3. Any other state or federal agency;
4. Any hospital;
5. Any clinic;
6. Any medical society;
7. Any third party payor, health insurer, or any other health care benefit plan;
8. Any entity processing this application;
9. Any entity which ever utilizes, relies on, or processes this application;
10. Any individual or entity providing any information about my personal or professional background, or my ethical, physical or mental qualifications to practice, or obtain licensure, or any other status as applied for in this application;
11. Any other entity which may ever be involved in any respect with this application; and
12. Any and all agents, employees, and authorized representatives of any of the above entities.

Pursuant to SDCL 22-29-9.1, I now again assert and I declare and affirm under the penalties of perjury that this application, and all information I have provided, has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I have not only read all of the previous questions and answered them completely and truthfully, but I also state without reservation and unequivocally that I understand each and every above question. Moreover, I declare that should I at any time state that I did not read or understand the previous questions or that the application was in any way confusing as to questions it asks, or statements required of me, such statements by myself will be grounds for the users to immediately cease all processing of this application, and I acknowledge that I am not eligible for licensure in South Dakota, or clinical privileges, status as a participating provider, or member provider of any health plan or provider of services for any third party payor, professional society, or other health care entity. I also state that should users of this application discover any derogatory information regarding my personal background, that was not disclosed when completing this application, the users may immediately cease all processing of this application, and I acknowledge hereto that such shall disqualify me for licensure in South Dakota, as well as privileges or participation as a provider or any other status applied for by this application.

In addition, I further understand that my submission of this application and actions subsequent thereto, but prior to licensure, shall bear directly upon my qualifications for licensure, and I fully understand that the South Dakota State Board of Medical and Osteopathic Examiners may consider all such actions in its determination whether to grant licensure. To that end, I assert that any unprofessional or harassing behavior on my part regarding submission of this application or its subsequent processing as it relates to contacts with Board members, employees of Board members, Board staff, any other individual involved in the processing of this application, whether related to licensure, requests for clinical privileges, requests to become a participant for any third party payor, or otherwise, or any other person will again constitute grounds for the immediate cessation of all processing of this application and will disqualify myself for licensure in South Dakota. A determination regarding derogatory information or of unprofessional or harassing behavior shall be the sole determination of the South Dakota State Board of Medical and Osteopathic Examiners, or any of the entities described above, and I will not assert that any other entity, judicial, or otherwise, may make such determination.

I further understand that cessation of processing of this application by the users as a result of actions by myself as described above will not require the South Dakota State Board of Medical and Osteopathic Examiners, or any other users of this application, to offer me a hearing or any other due process right, or any other statutory or constitutional rights, and that I will not assert that I am entitled to a hearing or any other due process rights, or any other statutory or constitutional rights that I may enjoy pursuant to SDCL 1-26, SDCL 36-4, the South Dakota Constitution, or the U.S. Constitution, or any hospital, or third party payors' bylaws or regulations or any other entities' provisions for a hearing or other due process rights. I hereby waive any and all due process rights and any other statutory or constitutional rights that I may enjoy as it relates to all matters described above and in any manner related to this application.

Printed Name of Applicant _____

Signature of Applicant _____

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

Notary Public _____
(Seal)

My Commission expires: _____

Application Addendum

Medicare/Champus Penalty Statement: This statement is required by Medicare/Champus.

Penalty statement according to the Federal Register dated August 31, 1984, and effective October 1, 1984.

"Notice to All Physicians"

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient as attested to by the patient's attending physician by virtue of his or her signature on the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

Signature: _____ Date: _____

Name: _____
(Please print or type)

Continuing Medical Education Attestation

Please read the following attestation carefully before signing and dating the statement.

I hereby certify that I have a sufficient number of CME credits to meet the requirements and attest that an appropriate percentage relate to my specialty. I understand that these credits may be audited by any entity utilizing this application. I also certify and understand that my failure to maintain sufficient CME credits as required by the various entities utilizing this application may result in my immediate loss of licensure, clinical privileges, membership as a participating provider of any third party payor, membership in any professional society, or any other health care entity utilizing and relying upon this application as determined solely by the entity or entities that audited my CME credits and discovered an insufficiency. I also assert, certify, and understand that I am not entitled to any hearing on this issue, and I will not assert that I am entitled to a hearing on this issue or that I am entitled to any other due process right pursuant to any South Dakota statute, the South Dakota Constitution, the U. S. Constitution, or bylaws or regulations of any entity utilizing and relying upon this application.

Signature: _____ Date: _____

Name: _____
(Please print or type)

Signature/DEA Verification

Pharmacies are required to maintain signatures and DEA numbers on file for all physicians.

Signature: _____ Date: _____

Name: _____ DEA Number: _____
(Please print or type)

Office Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Specialty: _____

Malpractice Litigation
Confidential Information

If you answered yes to disclosure question #18 on the Current Disclosure question page, please complete the following form. For each lawsuit, please furnish the following and attach a copy of the complaint including your response to the complaint and level of participation. It is your responsibility to provide external verification (i.e. statement from an attorney, court records, etc.) of your response. You may choose to have your attorney complete this form. Please make additional copies of this form if needed.

Name(s) of plaintiff(s) or complainant(s)

Month/Day/Year of Incident

Where Incident Occurred

Describe the Nature of Incident (Complaint, Allegation)

Provide a Narrative Description of your Participation/Level of Care

Outcome of Incident

☐ Pending ☐ Dropped/Settled/Closed – no payment ☐ Date Closed ____/____/____ ☐ Verdict for you – no payment

☐ Dropped/Settled/Closed with payment, amount: _____ ☐ Dismissed with prejudice

☐ Verdict for plaintiff, amount: _____ ☐ Dismissed without prejudice

Represented by Legal Counsel for this claim/malpractice lawsuit? ☐ Yes ☐ No If yes, give the name and address of counsel.

Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____

Insurance company that provided coverage for this claim:

Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Policy Number: _____

Signature: _____ Date: _____

Print Name: _____ Phone Number: _____

HOSPITAL AFFILIATION ADDENDUM

(Please make as many extra copies as necessary)

From: ___/___/___ Facility Name: ______________________________

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

Department Name: ______________________________

Department Chairperson or Chief of Staff: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number (if known): ______________ Fax Number (if known): ______________

From: ___/___/___ Facility Name: ______________________________

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

Department Name: ______________________________

Department Chairperson or Chief of Staff: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number (if known): ______________ Fax Number (if known): ______________

From: ___/___/___ Facility Name: ______________________________

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

Department Name: ______________________________

Department Chairperson or Chief of Staff: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number (if known): ______________ Fax Number (if known): ______________

From: ___/___/___ Facility Name: ______________________________

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

Department Name: ______________________________

Department Chairperson or Chief of Staff: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number (if known): ______________ Fax Number (if known): ______________

From: ___/___/___ Facility Name: ______________________________

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

Department Name: ______________________________

Department Chairperson or Chief of Staff: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number (if known): ______________ Fax Number (if known): ______________

Health Disclosure Questions

1. ☐ Yes ☐ No Do you have a physical or mental condition which would preclude you from performing the essential functions of your practice, job, or in the exercise of practice privileges, with or without reasonable accommodation? *Regardless of how this question is answered, the application will be processed in the usual manner. If you have answered this question affirmatively and are found to be professionally qualified for licensure or medical staff appointment and the clinical privileges requested, you will be given an opportunity to meet with the appropriate entity to determine what accommodations are necessary or feasible to allow you to practice safely.*

2. ☐ Yes ☐ No Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice without posing a health risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

3. ☐ Yes ☐ No Are you currently using illegal drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

4. ☐ Yes ☐ No Have you used illegal drugs within the last two years? ("Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

Signature: _____ Date: _____

Name: _____

(Please print or type)

AMA Self Designation of Specialties	AMA
Allergy	A
Adolescent Medicine (Pediatrics)	ADL
Addiction Medicine	ADM
Addiction Psychiatry	ADP
Allergy & Immunology	AI
Clinical Laboratory Immunology	ALI
Aerospace Medicine	AM
Adolescent Medicine (Internal Medicine)	AMI
Anesthesiology	AN
Pain Management (Anesthesiology)	APM
Abdominal Radiology	AR
Abdominal Surgery	AS
Anatomic Pathology	ATP
Blood Banking/Transfusion Medicine	BBK
Clinical Biochemical Genetics	CBG
Critical Care Medicine (Anesthesiology)	CCA
Clinical Cytogenetics	CCG
Critical Care Medicine (Internal Medicine)	CCM
Pediatric Critical Care Medicine	CCP
Surgical Critical Care (Surgery)	CCS
Cardiovascular Disease	CD
Craniofacial Surgery	CFS
Clinical Genetics	CG
Child Neurology	CHN
Child and Adolescent Psychiatry	CHP
Clinical Pathology	CLP
Clinical Molecular Genetics	CMG
Clinical Neurophysiology	CN
Colon & Rectal Surgery	CRS
Cardiothoracic Surgery	CTS
Dermatology	D
Developmental-Behavioral Pediatrics	DBP
Clinical and Laboratory Dermatological Immunology	DDL
Diabetes	DIA
Dermatopathology	DMP
Diagnostic Radiology	DR
Dermatologic Surgery	DS
Emergency Medicine	EM
Endocrinology, Diabetes and Metabolism	END
Epidemiology	EP
Sports Medicine (Emergency Medicine)	ESM
Medical Toxicology (Emergency Medicine)	ETX
Forensic Pathology	FOP
Family Practice	FP
Geriatric Medicine (Family Practice)	FPG
Facial Plastic Surgery	FPS
Sports Medicine (Family Practice)	FSM
Gastroenterology	GE
Gynecological Oncology	GO
General Practice	GP
General Preventive Medicine	GPM
General Surgery	GS
Gynecology	GYN
Hematology (Internal Medicine)	HEM
Hepatology	HEP
Hematology (Pathology)	HMP
Head & Neck Surgery	HNS
Hospitalist	HOS
Hand Surgery	HS
Interventional Cardiology	IC
Clinical Cardiac Electrophysiology	ICE
Infectious Disease	ID
Immunology	IG
Clinical and Laboratory Immunology (Internal Medicine)	ILI
Internal Medicine	IM
Geriatric Medicine (Internal Medicine)	IMG
Sports Medicine (Internal Medicine)	ISM
Legal Medicine	LM
Medical Management	MDM
Maternal & Fetal Medicine	MFM
Medical Genetics	MG
Molecular Genetic Path (Med Genetics)	MGG
Molecular Genetic Path (Pathology)	MGP
Medical Microbiology	MM
Internal Medicine/Pediatrics	MPD
Public Health & General Preventive Medicine	MPH
Musculoskeletal Radiology	MSR
Neurology	N
Neurodevelopmental Disabilities (Psych)	NDN
Neurodevelopmental Disabilities (Ped)	NDP
Nephrology	NEP
Nuclear Medicine	NM
Neuropathology	NP
Neonatal-Perinatal Medicine	NPM
Hematology/Oncology	OH

AMA Self Designation of Specialties	AMA
Nuclear Radiology	NR
Neurology/Diagnostic Neurology/Neuroradiology	NRN
Neurological Surgery	NS
Pediatric Surgery (Neurology)	NSP
Nutrition	NTR
Adult Reconstructive Orthopedics	OAR
Obstetrics-Gynecology	OBG
Obstetrics	OBS
Critical Care Medicine (Obstetrics & Gynecology)	OCC
Foot and Ankle Orthopedics	OFA
Occupational Medicine	OM
Other	OS
Osteopathic Manipulative Medicine	OMM
Musculoskeletal Oncology	OMO
Medical Oncology	ON
Pediatric Orthopedics	OP
Ophthalmology	OPH
Orthopedic Surgery	ORS
Sports Medicine (Orthopedic Surgery)	OSM
Orthopedic Surgery of the Spine	OSS
Otology/Neurotology	OT
Otolaryngology	OTO
Orthopedic Trauma	OTR
Psychiatry	P
Clinical Pharmacology	PA
Pediatric Anesthesiology	PAN
Pulmonary Critical Care Medicine	PCC
Chemical Pathology	PCH
Cytopathology	PCP
Pediatrics	PD
Pediatric Allergy	PDA
Pediatric Cardiology	PDC
Pediatric Endocrinology	PDE
Pediatric Infectious Disease	PDI
Pediatric Otolaryngology	PDO
Pediatric Cardiothoracic Surgery	PCS
Pediatric Pulmonology	PDP
Pediatric Radiology	PDR
Pediatric Surgery	PDS
Medical Toxicology (Pediatrics)	PDT
Pediatric Emergency Medicine (Emergency Medicine)	PE
Pediatric Emergency Medicine (Pediatrics)	PEM
Forensic Psychiatry	PFP
Pediatric Gastroenterology	PG
Pediatric Hematology-Oncology	PHO
Pharmaceutical Medicine	PHM
Clinical and Laboratory Immunology (Pediatrics)	PLI
Palliative Medicine	PLM
Physical Medicine & Rehabilitation	PM
Pain Management	PMD
Pediatric Nephrology	PN
Pediatric Ophthalmology	PO
Pediatric Pathology	PP
Pediatric Rheumatology	PPR
Pain Management (Physical Med & Rehab)	PMR
Plastic Surgery	PS
Sports Medicine (Pediatrics)	PSM
Anatomic/Clinical Pathology	PTH
Medical Toxicology (Preventative Medicine)	PTX
Pulmonary Diseases	PUL
Sports Medicine (Physical Med & Rehab)	PMM
Psychoanalysis	PYA
Geriatric Psychiatry	PYG
Radiology	R
Reproductive Endocrinology	REN
Rheumatology	RHU
Pediatric Rehabilitation Medicine	PRM
Neuroradiology	RNR
Radiation Oncology	RO
Radiological Physics	RP
Spinal Cord Injury	SCI
Sleep Medicine	SM
Surgical Oncology	SO
Selective Pathology	SP
Trauma Surgery	TRS
Transplant Surgery	TTS
Urology	U
Undersea Medicine	UM
Pediatric Urology	UP
Plastic Surgery with the Head and Neck	PSH
Thoracic Surgery	TS
Unspecified	US
Vascular and Interventional Radiology	VIR
Vascular Medicine	VM
General Vascular Surgery	VS

Updated: 3/1/2003