

Mailing List Order Form

South Dakota Statutes provide that certain public records, which are not confidential or otherwise protected, are open to inspection and may be released or distributed for a reasonable fee. The South Dakota Board of Medical & Osteopathic Examiners does not release licensure database information to individuals/organizations performing credentialing or licensure verification services.

DELIVERY TIMEFRAME: Orders are only processed on the 15th of each month. Any order received on the 14th or later will be processed on the 15th of the following month.

DELIVERY METHOD: You will receive an email with a Comma Separated Value (CSV) file which is compatible with spreadsheet programs like Microsoft Excel.

INCLUDED DATA: The file will include the names, gender and work mailing addresses of participating individuals. Specialties will be provided with Physicians only.

IMPORTANT DISCLAIMER: This mailing list may not have 100% of all licensees because individuals have the right to remove themselves from the list and this office makes every reasonable effort to honor these requests.

Statistics cannot be run on a mailing list because of the reason listed above.

Verification or credentialing cannot be performed on a mailing list because of the reason listed above. Primary source verifications can be purchased separately through our "Online License Verification" system which is linked to our website.

1. Name of Requestor: _____			
Organization: _____			
Mailing Address: _____			
Phone: _____	Fax: _____	Email (required): _____	

2. Please select the list(s) you would like (each list is \$100.00):	
<input type="checkbox"/> Athletic Trainer	<input type="checkbox"/> Occupational Therapy Assistant
<input type="checkbox"/> EMT – Intermediate	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> EMT – Paramedic	<input type="checkbox"/> Physical Therapy Assistant
<input type="checkbox"/> Dietitian/Nutritionist	<input type="checkbox"/> Physician (MD/DO)
<input type="checkbox"/> Medical Assistant	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Respiratory Care Practitioner

3. Method of Payment for fee (each list is \$100.00):	
Total Cost request: _____	
<input type="checkbox"/> Check (Make payable to: SDBMOE)	<input type="checkbox"/> Credit Card (Use the following area)
Credit Card Information	
Credit Card #:	Exp Date (mm/yy):
Name on card:	
Billing address of card:	
Signature of Card Holder:	Date of Signature:

**Mail completed form to: SD Board of Medical & Osteopathic Examiners
101 N Main Ave, Suite 301
Sioux Falls, SD 57104**

If using credit card, fax completed form to: 605-367-7786