MA Supervision Registration Form

Note: A Medical Assistant must be supervised by a licensed physician, licensed physician assistant or a licensed advanced practice nurse. (§36-9B-1)

Medical Assistant

Name of Medical Assistant _____

South Dakota Registration Number _____

Practice Address:

Street Address _____

City _____ State _____ Postal Code _____

Home Phone Number _____

Work Phone Number _____

Email Address _____

Proposed Supervising Provider(s)

1. Name _____ ☐ MD/DO ☐ PA ☐ CNP ☐ CNM

   License Number: _____ (If unknown, leave blank)

2. Name _____ ☐ MD/DO ☐ PA ☐ CNP ☐ CNM

   License Number: _____ (If unknown, leave blank)

3. Name _____ ☐ MD/DO ☐ PA ☐ CNP ☐ CNM

   License Number: _____ (If unknown, leave blank)

4. Name _____ ☐ MD/DO ☐ PA ☐ CNP ☐ CNM

   License Number: _____ (If unknown, leave blank)

I certify that the above information is true and accurate.

_____ _____

Signature of Medical Assistant Date

Send To: **SDBMOE**
101 N Main Ave Suite 301
Sioux Falls, SD 57104