SDBMOE Web User Authorized Agent Registration
(Submit multiple forms if needed)

License, Certificate, Registration, Permit Holder:

Name: _____

Facility: _____

Street Address _____

City _____ State _____ Postal Code _____

Phone Number _____ Email Address _____

Licensure Number _____

Licensure Type (Circle):

Advanced Life Support(ALS) Athletic Trainer Genetic Counselor Dietitian/Nutritionist

Medical Assistant Physician Surgeon Occupational Therapist Occupational Therapy Assistant

Physical Therapist Physical Therapist Assistant Physician Assistant Respiratory Therapist

Medical Corporation or Limited Liability Company Physician Assistant Corporation or Limited Liability Company

Authorized Agents **(Indicate the individuals who are authorized to perform tasks and access information on the Website)**

Name: _____ Email Address: _____

Phone Number: _____

Name: _____ Email Address: _____

Phone Number: _____

Name: _____ Email Address: _____

Phone Number: _____

Name: _____ Email Address: _____

Phone Number: _____

I authorize the above named Authorized Agent to access my online account (through his/her own account only), change my information, complete and submit applications and forms on the SDBMOE website only after I have reviewed and approved the information entered. I understand I will be held accountable for all information entered and submitted to the board office by the Authorized Agent. I understand this remains in effect indefinitely or until either party contacts the Board office in writing to terminate the agreement.

_____ _____

Signature of Licensure Holder Date

FAX: 605-367-7786 EMAIL: SDBMOE@STATE.SD.US WEB SITE: SDBMOE.GOV