

## 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 METHOD:** You will be emailed a file formatted to print the labels on an Avery 5162 template.

**INCLUDED DATA:** The file only will include the names and work mailing addresses of participating individuals.

**IMPORTANT DISCLAIMER:** This mailing list does not include all licensees because individuals have the right to remove themselves from the list or may not have provided a practice address. The list is only valid and accurate at the time it was processed.

The mailing list is not intended to be used for statistical, credentialing, or license verification purposes. License verifications can be purchased on our website [www.sdbmoe.gov](http://www.sdbmoe.gov).

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

<b>2. Please select the list(s) you would like</b> (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

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

**Click here to submit this form by email:**

**(this may not work if you don't have Microsoft Outlook)**

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

**Fax completed form to: 605-367-7786**