

**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(EMT)	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 Web site)**

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 Agents to login for me, create an account for me, change my information, and submit official applications and forms on the SDBMOE Web site for me. I understand this remains in effect indefinitely and that I must contact the SDBMOE when such authorization is no longer required or desired.***

\_\_\_\_\_  
Signature of Licensure Holder

\_\_\_\_\_  
Date