

Replacement License, Certificate or Registration Request Form

Every reasonable effort to ensure that original documents reached our licensees has been made, including first class postage. If the US Postal Service returned renewed licenses or registrations to the Board, additional efforts were made to again reach the intended recipients. The Board is not responsible for mishaps that occur while mail is in the care of the US Postal Service.

1. Name of Requestor: _____

Phone: _____ Fax: _____ Email: _____

2. Check Profession:

- | | |
|--|---|
| <input type="checkbox"/> Advanced Life Support Personnel (EMT) | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Athletic Trainer | <input type="checkbox"/> Physical Therapy Assistant |
| <input type="checkbox"/> Genetic Counselor | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Dietitian/Nutritionist | <input type="checkbox"/> Physician – Resident Certificate |
| <input type="checkbox"/> Medical Assistant | <input type="checkbox"/> Physician – 60 Day Certificate |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Occupational Therapy Assistant | <input type="checkbox"/> Respiratory Care Practitioner |

3. Licensee Information:

I hereby apply for a replacement license, certificate or registration card and enclose the payment of \$10.00. The circumstances regarding the loss or destruction of my original license, certificate or registration card are as follows: _____

List **ALL** names: correct spelling; current & any additional names (i.e. maiden, married, & other)
Legibly print name(s) _____

SD license number: _____ **Date of Birth:** _____ **SS #:** _____

4. Send Replacement card to:

Street _____

City _____ State _____ Zip Code _____

For PRIORITY delivery, include stamped and addressed envelope, or Fed Ex or other overnight delivery company account number: _____

5. Method of Payment for \$10 fee:

- Check (Make payable to: SDBMOE)** **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