

Renewal Instructions

1. Complete the application to the best of your abilities. Signature required in all designated spaces. An incomplete application will be rejected.
2. Enclose a copy of your state Certificate of Incorporation provided by the Secretary of State. (The attorney for your corporation should be able to help you with this.)
3. All shareholders and officers must be listed on this form. The form must be signed by an authorized officer.
4. Mail your renewal materials, including your method of payment, to:

SDBMOE
101 N Main Ave, Ste 301
Sioux Falls, SD 57104
5. If you need confirmation that your application has arrived in this office, use a mailing method with tracking capabilities. This office will NOT provide verification of mail arrival or receipt.
6. Please allow three (3) to four (4) weeks to receive an updated license/certificate/registration card. This will allow processing and mailing to the preferred mailing address that you have chosen.
7. If after six (6) weeks, you have not received a new wall certificate, please contact the Board at <http://medicine.sd.gov>. Note: there is a \$25 charge for replacing a certificate once one has been mailed to the preferred mailing address that you have chosen.

Name of Corporation: _____ Date: _____

Medical / PA Corp

Renewal Application for Medical / PA Corporation and Medical Limited Liability Company, LLC

1. Name: Indicate the full legal name of your corporation. If the name of the corporation has changed at any time, you must submit a copy of the legal document supporting the corporate name change.

Current Name	_____
Previous Name	_____
Specialty or emphasis of practice	_____
Contact Person	_____

2. Address/Phone

Street	_____				
City	_____	State/Province	_____	ZIP Code	_____
Telephone	_____	Fax	_____		
Alternate Phone (e.g. pager or cell phone)	_____				
E-mail address	_____				
My primary practice location is in this SD county	_____				

3. The Names and Addresses of the Shareholders of the Medical / PA Corporation or the Members of the LLC are:
(use additional sheet if necessary)

Name	Street Address	City	State	ZIP
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. The Names and Addresses of the Officers of the Corporation or LLC are:
(use additional sheet if necessary)

Name	Street Address	City	State	ZIP
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Name of Corporation: _____ Date: _____

Medical / PA Corp

I have enclosed a copy of our Certificate of Incorporation provided by the Secretary of State.
(The attorney for your corporation should be able to help you with this or use www.sdsos.gov.)

I have enclosed the fee of **\$100.00** for renewal of a South Dakota Certificate of Registration.

Make Check payable to SDBMOE or complete below for credit card:

Credit Card number: _____
Expiration Date: (mm/yyyy) _____
Print Name of person signing credit card: _____
Signature _____ Date _____

REGARDING DEADLINES AND REGISTRATION EXPIRATION:

I, _____ hereby state that I am informed and understand the following deadlines and expirations:

By December 31, 2012, my completed renewal materials must be received and be reviewed by the SDBMOE office to ensure receipt of my renewal or renewed license prior to the expiration of my current license. By this Document, I am informed and acknowledge that my completed renewal materials will be processed in the order received, and that I will receive my renewal license as soon as practicable. I also acknowledge that it takes time to process my application and therefore, I understand that the sooner I send my application to the SDBMOE, the sooner I can anticipate it being processed and approved.

Further, I understand that in the event that my completed renewal items arrive or are postmarked after December 31, 2012, that my Certificate of Registration shall automatically forfeit.

The Statement above must be signed by any authorized Officer of the Corporation or LLC.	
Print or Type Name:	_____
Date:	_____
Applicant Signature:	_____
Title:	_____

Name of Corporation: _____ Date: _____

Medical / PA Corp