Est. 1917
South Dakota Board of Nursing
SDBON

SOUTH DAKOTA BOARD OF NURSING

4305 S. Louise Ave., Suite 201 l Sioux Falls, SD 57106-3115
P: 605-362-2760 **l** sduap@state.sd.us **l** **https://doh.sd.gov/boards/nursing/**

CNA Reinstatement Application: Competency Evaluation Program Required

A registered Certified Nurse Aide, *who **does not have** the required minimum of 12 hours of training per year as required in ARSD 44:74:02:02(4) **or** the required minimum of 12 hours of employment performing nursing or nursing-related services for monetary compensation during the preceding 24 months*, must retake and pass the Competency Evaluation Program pursuant to ARSD 44:74:02:25. The Competency Evaluation Program consists of the written (or oral) exam and the skills exam.

Directions:

1. Complete this application and submit to the Board of Nursing. The Board will process within ***5-7 business days***. After approval;
2. The Board will email a letter to the CNA and a copy to the SD Healthcare Association (SDHCA);
3. The CNA may then contact the SDHCA to register to take the Competency Evaluation Program (exams);
4. After passing the exams, the SDHCA will notify the Board and the Board will then make the CNA active on the CNA registry.

Name: First_____ Middle_____ Last _____

Other names used:_____

Mailing Address:_____ City_____ State_____ Zip_____

Telephone: Home: ( ) _____ Cell: ( ) _____ Other: ( ) _____

Email: _____

CNA Registry #:_____ **Expiration Date:**_____

Disciplinary Questions: ***If "YES"*** *is answered to any question, attach a detailed explanation and copies of charges or citations and ALL communication (to and from) with the citing agency AND the court jurisdiction, also include evidence of completion/compliance with court requirements.*

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations that have not previously been reported to the Department of Health?	☐ Yes	☐ No
2.	Have you ever had an allegation against you for abuse, neglect, or misappropriation of property?	☐ Yes	☐ No
3.	Do you have a record of abuse, neglect, misappropriation, or is there any pending action?	☐ Yes	☐ No
3.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	☐ Yes	☐ No
4.	Are you currently being investigated or is disciplinary action pending against any license(s) or certificate(s) held by you?	☐ Yes	☐ No
5.	Has any license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	☐ Yes	☐ No
6.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital, nursing facility, or other healthcare provider entity?	☐ Yes	☐ No
7.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	☐ Yes	☐ No
8.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	☐ Yes	☐ No
9.	*Do you currently owe child support arrearages in the amount of $1,000 or more?*	☐ *Yes*	☐ *No*
10.	*Have you ever had action taken against you by the Office of Inspector General (OIG)?*	☐ *Yes*	☐ *No*

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Employment Questions:

1.	During the preceding 24 months, have you been employed a minimum of 12 hours performing nursing or nursing-related services for monetary compensation?	□ Yes	□ No
2.	During the preceding 24 months, have you completed a minimum of 12 hours per year (24 hours total) of in-service education related to the results of a performance review or on resident needs?	□ Yes	□ No

***If "YES"** is answered to question 1 or 2, sign the form and request your current, or previous employer, to complete the **Employer Verification** below, then send the completed application to the Board office.*
***If "NO"** is answered to **both** questions, sign the form and send completed application to the Board office.*

I declare and affirm that, to the best of my knowledge and belief, all information provided on this application is complete, true, and correct.

CNA Signature: _____ ***Date:*** _____

Employer Verification

Name of Employer: _____

Employer Representative Name/Title (Please Print): _____

Address: _____

City, ST, Zip: _____

Telephone: _____

Employer Representative: *Respond to these questions to the best of your knowledge.*

1.	Does this applicant have a record of abuse, neglect, misappropriation, or any pending action of abuse, neglect, or misappropriation?	□ Yes	□ No
2.	Has this applicant, during the preceding 24 months, been employed a minimum of 12 hours performing nursing or nursing-related services for monetary compensation?	□ Yes	□ No
	• If yes, provide the total number of hours:		
3.	Has this applicant during the preceding 24 months, completed a minimum of 12 hours per year (24 hours total) of in-service education related to the results of a performance review or on resident needs?	□ Yes	□ No

I declare and affirm that, to the best of my knowledge, all information provided on this Verification is complete, true, and correct.

Signature of Employer Representative: _____

Date: _____

All questions must be answered, an incomplete application will result in a delay in processing!

Email completed application to sduap@state.sd.us
Or mail to the address listed at the top of this application.