SOUTH DAKOTA BOARD OF NURSING

4305 S. Louise Ave., Suite 201 I Sioux Falls, SD 57106-3115
605-362-2760 I **https://doh.sd.gov/boards/nursing/**

CNP Practice Verification – Form 3

All applicants for licensure are required to practice a minimum of 1,040 hours as a *licensed* CNP to practice without a collaborative agreement. *If you cannot verify 1,040 hours of licensed practice,* submit a completed Collaborative Agreement with a SD licensed physician or SD licensed CNP.

Return this completed form via email (sdbon@state.sd.us) or mail to the SD Board of Nursing.

Name: First_____Middle_____Last _____

Social Security #: _____

Telephone: (___) _____ **Email**: _____

I, hereby request and authorize my employer / former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

_____ _____
Signature Date

This section to be completed by Employer / Agency Representative:
(Provide Employment Hours Within the Preceding 5 Years)

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the above-named individual has practiced in the role of a **licensed** CNP:

From _____
Month/Date/Year

To _____
Month/Date/Year

Total number of hours: _____

I, the undersigned, declare and affirm the information provided above for purpose of licensure is true and correct.

_____ _____
Signature of Agency Representative/Title Date

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip Code:_____

Telephone: _____