SOUTH DAKOTA BOARD OF NURSING
4305 S. Louise Ave., Suite 201 | Sioux Falls, SD 57106-3115
605-362-2760 | https://doh.sd.gov/boards/nursing/

Medication Administration Training Program

Faculty Change Application

To request changes to an approved MATP, complete and submit this application to the Board by mail or email to sduap@state.sd.us. **Notice of approval status will be emailed to the Primary RN Instructor issued in 5 – 7 business days.**

Name of Program: _____

Address: _____

Phone Number: _____

1. Identify name of Primary RN Instructor: _____
2. E-mail Address: _____
3. Phone number: _____
4. List all RN instructors who teach a portion of the training program. *Instructors must have a minimum of 2 years clinical RN nursing experience.*

List Names of RN Instructor(s) for the sixteen-hour Theoretical Portion and/or four-hour Clinical/Lab Portion of Program	**RN License Information**		I verify that this RN has a minimum of two years of clinical RN experience:		License Verification *Completed by SDBON*
	State	Number			
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	

5. List all LPN instructors who teach the four-hour clinical/lab portion of the training program. *Instructors must have a minimum of 2 years clinical LPN nursing experience.*

List Names of LPN Instructor(s) for the four-hour Clinical/Lab Portion of Program	**LPN License Information**		I verify that this LPN has a minimum of two years clinical LPN experience:		License Verification *Completed by SDBON*
	State	Number			
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	

Affidavit: I, the undersigned, declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I further agree, as the primary RN instructor, to teach the medication aide training program using one of the SDBON's approved curriculums, the Clinical Skills Checklist, the Enrolled Student Log form, and will issue successful students a Certificate of Completion.

Primary RN Instructor Applicant's Signature: _____ **Date:** _____

Completed by the SDBON

Date Application Approved:	Expiration Date of Approval:	Board Representative: