



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 Waiver Application

- This application is **ONLY** for individuals who are **NOT** administering medications to clients in a skilled nursing facility, assisted living center, or hospital.
- Send this completed application to the Board office with requested documentation that supports your request to waive the sixteen-hour portion of the medication administration training program (MATP).
- *All applicants* must complete a MATP's required four-hour clinical/lab portion of the program, a competency evaluation, and must pass the MATP's final exam.

First Name: _____ Middle Initial: _____ Last Name: _____

Other Names Previously Used: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

- If you are a **Nursing Student**, submit the following to the Board:
 - This application, and
 - A copy of transcript, grade report, or other documentation, from your nursing education program that verifies successful completion of a **Pharmacology course** and a **Fundamentals in Nursing course** that includes theory, lab, and clinical in the area of medication administration.
- If you are **Endorsing as a Medication Aide from Another State**: You must have completed a high school education or GED. Submit the following to the Board:
 - This application;
 - Documentation to support current registration on another state's medication aide registry or employment as a medication aide for a minimum of 12 hours during the preceding two years;
 - Documentation to support completion of another state's medication training program that was a minimum of 20-hours in length.
- If you hold an **Inactive LPN or RN license**, submit this application and the following information:

License Number: _____ State: _____ Expiration Date: _____

The SDBON will verify the license. If a nurse has had disciplinary action, the Board will review and determine whether or not medication administration tasks may be delegated to this individual.

NOTICE of approval/denial will be emailed to the RN instructor listed below within 5 – 7 business days.

Provide MATP Primary RN Instructor Information:

First Name: _____ Last Name: _____

Phone: _____ Email: _____