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/

Lapsed Medication Aide Renewal Application

The Medication Aide completes page 1 and an employer must complete page 2. Submit and email both pages together, send to sduap@state.sd.us. An incomplete application will result in a delay of processing an application and may result in denial of registration renewal. **Allow 5-7 business days to process application**.

Please Print

Name: **First**:___________________ **Middle**:__________ **Last**: ___________________

Other names previously used:_________________________________

SD Medication Aide Registry #: ___________________ **Expiration Date**: ___________________

Mailing Address:___________________ City: __________ State: ______ Zip: ________

Phone: Home: (   ) ______________ Cell: (   ) ______________ Other: (   ) ______________

Email: ______________________________ **Social Security #**: ___________________

Disciplinary Information:

Provide details and/or documentation to explain each question with a "yes" answer. Attach additional pages to the application if needed. If further information is required, you will be notified by the South Dakota Board of Nursing.

1.	Have you 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 South Dakota Board of Nursing?	☐ Yes	☐ No
2.	Is there any pending criminal prosecution against you which would constitute a felony?	☐ Yes	☐ No
3.	Have you had action taken against you for abuse, neglect, or misappropriation of property by a state or federal agency?	☐ 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 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 been treated for abuse or misuse of any alcohol or chemical substance since your last renewal?	☐ Yes	☐ No
7.	Do you currently owe child support arrearages in the amount of $1,000 or more?	☐ Yes	☐ No

Employment Information:

1.	I have been employed as medication aide within the last 2 years for at least 12 hours within a Skilled Nursing Facility, Assisted Living Center, or Hospital.	☐ Yes	☐ No
2.	Do you have a record of abuse, neglect, misappropriation, or is there any pending action?	☐ Yes	☐ No
3.	Did you work as a medication aide while your registration was lapsed?	☐ Yes	☐ No

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

Medication Aide Signature: ______________________________ **Date**:______________

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Medication Aide Registry Renewal Application

Employment Verification

Completed by Employer

A Medication Aide must submit verification of a minimum of 12 hours of employment within the preceding 2 years in a Skilled Nursing Facility, Assisted Living Center, or Hospital as a medication aide.

Please Print

Medication Aide Information:

First Name:______________________________ Last Name: ______________________________

SD Medication Aide Registry #: ________________________

Employer Information: (must be a Skilled Nursing Facility, Assisted Living Center, or Hospital)

Facility Name: ____

Address: ____

City, ST, Zip: ____

Phone: ________________________________

Employer Representative Name & Title: ____

Enter total # of hours: ____________ this individual worked as a ***medication aide*** during the preceding 24 consecutive months in above named facility.

☐ To the best of my knowledge, this applicant has no record of abuse, neglect, or misappropriation, nor is there any pending action. (Mark box to affirm statement; or contact the Board office if cannot affirm statement.)

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

Signature of Employer Representative: ____________________________________**Date:**______________

Email completed application to sduap@state.sd.us