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 Aide Endorsement Application

If any of the information is incorrect, incomplete, or illegible, processing may be delayed. An applicant will be notified if additional information is required. Submit completed application by mail or email to sduap@state.sd.us.

Allow up to 5-7 business days to process application.
Upon approval the proctor will be emailed the online test access information to allow you to take the exam.

Please Print

Name: First_____ Middle_____ Last _____

Other names previously used:_____

Mailing Address:_____ City_____ State_____ Zip_____
Street/PO Box

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

Email: _____

Date of Birth:_____

Social Security #: _____

Gender: ❑Male ❑Female ❑Other

Ethnicity: ❑Caucasian ❑Black ❑Hispanic ❑Asian/Pacific Islander ❑American Indian/Alaskan Native ❑Other

Disciplinary Information:

Please 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

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1. High school education information or equivalency information.

Name of High School or Equivalency Program	Location of School or Equivalency Program (City, State)	Year Diploma or Equivalency Received

2. Medication Aide Equivalency Education Information.

☐ **Attach a copy** of a certificate of completion for Medication Aide Training Program that lists the name and location of the program, and date completed. The program must have been at least 20-hours in length; *and*

☐ **Attach a copy** of verification that you are actively registered as a medication aide on another state's medication aide registry.

3. RN Attestation.

I, _____, RN verify that I completed 4-hours medication administration clinical/lab training with the individual identified on this application, that the applicant is capable of performing all the skills listed on the SD Board of Nursing's approved Skills Competency Checklist safely and competently, and that the applicant is eligible to take the medication aide exam.

RN Signature: _____ **RN License #:** _____ **Date:** _____

4. SD Board of Nursing Approved Test Proctor Information.

Name of SDBON Approved Proctor:	Proctor's Phone:	Proctor's Email Address:

5. Do you currently owe child support arrearages in the sum of $1,000 or more? ❒YES ❒NO

If YES, contact South Dakota Department of Social Services to make arrangements prior to issuance of med aide registration.

6. Affidavit

I, the undersigned, declare and affirm under the penalties of perjury that this application for registration in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

_____ _____

Medication Aide Applicant Signature **Date**