



SOUTH DAKOTA BOARD OF NURSING

4305 S. Louise Ave., Suite 201 | Sioux Falls, SD 57106-3115
 605-362-2760 | <https://www.sdbon.org/>

CNA Lapsed Reinstatement Application

First Name: _____ Middle _____ Last _____

Social Security #: _____ Email: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone: () _____

CNA Registry #: _____ Expiration Date: _____

Disciplinary Questions: *If “YES” is answered to any question, attach a detailed explanation and copies of charges or citations and ALL communication (to and from) with the citing agency AND the court jurisdiction, also include evidence of completion/compliance with court requirements.*

1.	Have you ever 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 Board of Nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Have you ever had an allegation against you for abuse, neglect, or misappropriation of property?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Are you currently being investigated or is disciplinary action pending against any license(s) or certificate(s) held by you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Has any license or certificate ever 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital, nursing facility, or other healthcare provider entity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Do you currently owe child support arrearages in the amount of \$1,000 or more?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



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Employment Questions:

1. Have you been employed a minimum of 12 hours performing nursing or nursing-related services for monetary compensation during the preceding 24 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you completed a minimum of 12 hours of in-service education annually during the preceding two years that included content on the topics listed below? (24 hours total)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> ● Effective communication; ● Client rights and facility responsibilities; ● Client abuse, neglect, exploitation, misappropriation of property, and procedures to report incidents; 	<ul style="list-style-type: none"> ● Dementia management training and client abuse prevention; ● Infection control; and ● Compliance and ethics. 	

If **“YES”** is answered to questions 1 and 2, sign the form and request your current, or previous employer, to complete the **Employer Verification** (below) then send the completed application to the Board office.

If **“NO”** is answered to questions 1 and/or 2, you are required to take and pass the CNA knowledge exam and a skills evaluation. The Board will send you an email, within 5 business days of receipt of your application, with instructions on how to complete the exam and skills evaluation.

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

CNA Signature: _____ **Date:** _____



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Employer Verification

Name of Employer: _____

Employer Representative Name/Title (Please Print):

Address: _____

City, ST, Zip: _____

Telephone: _____

Employer Representative:

Respond to these questions to the best of your knowledge.

1. Does this applicant have a record of abuse, neglect, misappropriation, or any pending action of abuse, neglect, or misappropriation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Has this applicant, during the preceding 24 months, been employed with a minimum of 12 hours performing nursing or nursing-related services for monetary compensation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> If yes, provide the total number of hours: 		
3. Has this applicant completed new employee training or in-service education on the following required topics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> Effective communication; Client rights and facility responsibilities; Client abuse, neglect, exploitation, misappropriation of property, and procedures to report incidents; 	<ul style="list-style-type: none"> Dementia management training and client abuse prevention; Infection control; and Compliance and ethics. 	

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

Employer Representative Signature: _____

Date: _____

All questions must be answered, an incomplete application will result in a delay in processing!

Email completed application to sduap@state.sd.us
Or mail to the address listed at the top of this application.