SOUTH DAKOTA BOARD OF NURSING
4305 S. Louise Ave., Suite 201 | Sioux Falls, SD 57106-3115
605-362-2760 | https://www.sdbon.org/

Application to Request Equivalency of Education for 75-Hour Nurse Aide Training

Nursing students and inactive or lapsed RNs and LPNs may request to meet the 75-hour Nurse Aide training requirement by equivalency of education. The Board grants approval for students actively or previously enrolled in Board-approved nursing education programs that have successfully completed (grade 'C' or better) courses that include nursing theory and clinical instruction which meet the 75-hour Nurse Aide training content required.

The Board will send written notice as to whether the applicant: (1) is granted approval to waive the Nurse Aide training program and is eligible to schedule and sit for the CNA knowledge exam and to complete the four Skills Evaluation Forms with an RN Skills Evaluator; or (2) is denied approval to waive the Nurse Aide training program and why.

Name: First:_____ Middle:_____ Last: _____

Mailing Address:_____ City_____ State_____ Zip_____

Telephone: Home/Cell (___)_____ **Email**:_____

Date of Birth:_____ **Social Security #:** _____

Disciplinary Information: If "YES" is answered to any of the disciplinary questions, please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court jurisdiction, including 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?	□ Yes	□ No
2.	Have you ever had an allegation against you for abuse, neglect, or misappropriation of property?	□ Yes	□ No
3.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	□ 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 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?	□ Yes	□ No
6.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital, nursing facility, or other healthcare provider entity?	□Yes	□ No
7.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	□ Yes	□ 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?	□ Yes	□ No
9.	Do you currently owe child support arrearages in the amount of $1,000 or more?	□ Yes	□ No

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Submit with this application:

☐ Copy of student's school transcript, grade report, or other school documentation supporting request
- Must have completed a nursing course(s) on fundamental nursing concepts and skills.

☐ Name of Nursing School: _____

OR

☐ Provide RN/LPN license number and state/jurisdiction of that license.

Number: _____ State: _____ Expiration Date: _____

***Note**: The Board will verify the licensure status of the nurse; if a nurse has had any disciplinary action, BON staff will review and determine whether or not the individual may be placed on the South Dakota Nurse Aide Registry.*

Applicant Signature: _____ **Date:** _____

Send this completed application and supporting documentation to the South Dakota Board of Nursing.

Director of Nursing or Nursing Faculty Member must attest that an approval for waiver of Nurse Aide training for this individual is appropriate. Complete and sign:

Nursing Facility:

Name/Title of DON or Faculty Member: _____

Address: _____

City ST Zip: _____

Telephone: _____ **Email:** _____

DON / Faculty Signature: _____ **Date:** _____

This section to be completed by the South Dakota Board of Nursing

Date Application Received:	Date Application Denied:
Date Approved:	Reason for Denial:
Board Representative:	Date Notice Sent to Student and / or Nursing Facility: