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South Dakota Board of Nursing
SDBON

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

Medication Administration Training Waiver Application: Registered Medication Aide

- This application is **ONLY** for individuals who will be administering medications 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 skills competency evaluation, and must pass the Board's final exam.

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

Other Names Previously Used: _____

Social Security #: _____ Date of Birth: _____

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

Phone: _____ Email: _____

Gender: ❑Male ❑Female

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

Waiver Information:

- 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 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.

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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Employment Information:

I will be employed as medication aide in a **Skilled Nursing Facility, Assisted Living Center, or Hospital**.	□ Yes	□ No
Name of employing facility:		
Do you have a record of abuse, neglect, misappropriation, or is there any pending action?	□ Yes	□ No

Proctor Information:
Name of SDBON approved proctor:

First Name:_____Last Name:_____

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.

Applicant Signature: _____**Date:**_____

RN Attestation

I verify that if the waiver is approved, this applicant will be required to complete a four-hour clinical/lab portion of a MATP program, a skills competency evaluation, pass the Board's final exam, and be registered with the Board prior to administering medications.

RN Signature: _____License #:_____

Date: _____ Phone: _____ Email: _____

NOTICE

Notice of approval/denial will be emailed to the RN instructor within 7 business days.