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

Registered Medication Aide (RMA) Applicant
Practice Setting Verification Form

A nursing representative at a skilled nursing facility, assisted living facility, or hospital must complete this form. The nursing representative must print and sign the form then submit to the Board at the address listed above or scan and email to SDUAP@state.sd.us.

1. RMA Applicant Information

Enter Last Name:

Enter First Name:

Enter Middle Initial:

Enter last four digits of Social Security Number:

Enter Date of Birth:

2. Facility Information (must be licensed by the SD Department of Health)

Enter Facility Name:

Enter Facility Address:

Enter Facility Phone Number:

3. Nursing Representative Information

Enter Last Name:

Enter First Name:

Enter Title and Credentials:

Enter Email Address:

4. Affidavit

I certify that all information provided on this form is true to the best of my knowledge and that the applicant listed above will be working in the role of a RMA in the facility listed above.

Signature: _____ Date: _____