



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/>

Assisted Living Center, Skilled Nursing Facility and Hospital

RN Attestation for Medication Aide Training Course Completion

This form must be completed to take the SDBON Medication Aide exam.

Applicant: Complete the top section of this form; then send to your RN Trainer to complete the bottom section of the form.

Email completed form to sduap@state.sd.us

Medication Aide Applicant Section

1. First Name: _____ Middle Initial: _____ Last Name: _____
2. Social Security #: _____
3. Date of Birth: _____ / _____ / _____

Signature: _____ **Date:** _____

RN Instructor Section

1. Name of SDBON Approved Medication Aide Training Program (MATP):

2. MATP Location: _____
3. Applicant's Date of Completion of MATP: _____
4. RN's First Name: _____ Middle Initial: _____ Last Name: _____
5. License Information: State: _____ RN License #: _____
6. Phone Number: _____ Email: _____

RN Attestation:

I verify that the Medication Aide Applicant identified on this application has completed a SD Board of Nursing approved 20-hour Medication Aide Training Course, is capable of performing all skills listed on the SD Board of Nursing's Approved Skills Competency Checklist safely and competently, and is eligible to take the Medication Aide exam.

RN Signature: _____ **Date:** _____