



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/>

Instructions to Reinstate Lapsed RN or LPN Nursing License

Lapsed Status: When a South Dakota nursing license is not renewed by the expiration date the license is placed on a lapsed status and must be reinstated prior to resuming practice. Once reinstatement requirements are met, you will be mailed a license renewal certificate that will be valid from the date of issuance to your second birthday thereafter.

Instructions: To reinstate a license, follow these steps carefully; if any information is incorrect, incomplete, or illegible, processing will be delayed. You will be notified in writing if additional information is required. Upon receipt of all forms and fees your application will be considered for reinstatement, pursuant to ARSD 20:48:03:12.

1. Submit completed **Application to Reinstate a Lapsed RN or LPN Nursing License**
2. Submit completed **Employment Verification Form**. Current nursing practice is required to retain an active license, you must verify employment/volunteer work in nursing of at least 140 hours in a 12-month period or 480 hours in 6 years.
3. Complete a **Criminal Background Check (CBC)** if you are declaring South Dakota as your primary state of residence and if you were originally licensed in South Dakota prior to July 2006.

South Dakota belongs to the Nurse Licensure Compact (NLC). All NLC states require applicants to complete a CBC to be issued a multistate license (MSL) at the time of initial nurse licensure. If you were originally licensed in South Dakota prior to July 2006, you did not complete a CBC. Because your license lapsed, you are required to complete a CBC. Email sdbon@state.sd.us or call the Board office to request a CBC packet be mailed to you: 605-362-2760.

4. Submit **Renewal and Reinstatement Fees** (as required pursuant to ARSD 20:48:16:01):

| | |
|--------------------|--------------|
| Renewal Fee: | \$115 |
| Reinstatement Fee: | \$50 |
| Total | \$165 |

5. Submit **Administrative Fine**: Practicing on a lapsed license is illegal pursuant to SDCL 36-9-49(9), 36-9-68(5), and 36-9-71. Pursuant to SDCL 36-1C-5, the Board can impose an administrative fine. The Board approved the following fines for nurses who worked on a lapsed license. If you have questions on the number of days your license has been lapsed, please contact the board office.

| | |
|------------------|-------|
| 90 days or less | \$0 |
| 91 – 365 days | \$100 |
| 366 – 730 days | \$200 |
| 731 or more days | \$300 |

You may appeal the administrative fine by requesting a contested case under SDCL 1-26; to do so, select the *Appeal Administrative Fine* option on the *Application to Reinstate a Lapsed RN or LPN Nursing License*. Submission of the application serves as your notice to appeal (notice must be submitted to the Board's Administrator within 20 calendar days of the service of this fine). Complete all other reinstatement requirements to proceed with requesting reinstatement of your license(s). You will be contacted within 5 business days regarding the contested case process.

6. **Payment:** Must be in the form of a money order payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany application. To pay by credit card you must call the board office.



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Application to Reinstate a Lapsed RN or LPN Nursing License

Name(Last): _____ (First): _____ (Middle): _____

Other Names Used: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

RN License number: _____ or LPN License number: _____

1. Explain why your license lapsed: _____
2. Have you worked in South Dakota on this lapsed license?
 - No
 - Yes: Where? _____

How many days? _____.

You are required to pay an administrative fine of:

| | |
|------------------|-------|
| 90 days or less | \$0 |
| 91 – 365 days | \$100 |
| 366 – 730 days | \$200 |
| 731 or more days | \$300 |

Mark this box if you are appealing the administrative fine and requesting a contested case under SDCL 1-26. Submission of this application serves as your notice to appeal; this notice must be submitted to the Board within 20 calendar days of the service of this fine. You will be contacted in 5 business days regarding the contested case process; your license will be reviewed and reinstated upon submission of this application and meeting all other reinstatement requirements.

3. South Dakota belongs to the Nurse Licensure Compact (NLC) and requires applicants to declare a **Primary State of Residence**: I declare _____ to be my primary state of residence. Primary state of residence is where you hold a driver’s license, pay taxes and/or vote. This state is referred to as my “home state” under the NLC and means that it is my “declared fixed permanent and principal home for legal purposes”.

The following can be used to document residency:

- Driver’s license with a home address.
- Voter registration card displaying a home address.
- Federal income tax return declaring the primary state of residence.
- Military Form No. 2058 – state of legal residence certificate.
- W2 from US Government or any bureau, division, or agency indicating declared state of residence.

4. Year you first obtained your SD nursing license: _____.

5. You are required to complete a **Criminal Background Check (CBC)** if you were originally licensed in South Dakota prior to July 2006. Email sdbon@state.sd.us or call 605-362-2760 to request a CBC packet mailed to you.

- All NLC states require applicants to complete a CBC at the time of initial licensure to be issued a multistate license. If you were originally licensed in South Dakota prior to July 2006, you did not complete a CBC.



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6. Are you employed by the military or practicing in a federal institution?

- Yes
- No

A federal government/military nurse who practices only in the federal or military system needs to only hold one license from *any* state or territory per U.S. federal government/military policy.

A federal or military nurse who *also* practices in a civilian health system is bound by the Compact law and rules, if the nurse has proof of residency in a Compact party state the nurse may be issued a Compact license with a multi-state practice privilege. A federal/military nurse who does not have proof of residency in a Compact party state may be issued a single-state license regardless of where the nurse is residing. A military/federal nurse may not hold a multi-state license from more than one Compact state at a time.

7. **Compliance Information:** Answer each question below, if you answer “YES” to any one of the questions, attach a detailed explanation and submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion / compliance with court requirements.

| | | | |
|----|--|------------------------------|-----------------------------|
| 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 board? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | 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 |
| 3. | Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Has any nursing 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? That have not previously been reported to the board? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Have you had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. | Have you been treated for abuse or misuse of any alcohol or chemical substance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. | Are you currently enrolled in an Alternative to Discipline Program? (i.e. SD HPAP.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. | Have you experienced a physical, emotional, or mental condition that has endangered or posed a direct threat to the health or safety of persons entrusted to your care or your ability to safely practice? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. | Do you currently owe child support arrearages in the amount of \$1000 or more? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

8. **Employment and Education Information:**

A. What type of nursing degree / credential qualified you for your first U.S. nursing license?

- | | |
|---|--|
| <input type="checkbox"/> Vocational / Practical Certificate Nursing | <input type="checkbox"/> Master's Degree – Nursing |
| <input type="checkbox"/> Diploma – Nursing | <input type="checkbox"/> Doctoral Degree – Nursing (PhD) |
| <input type="checkbox"/> Associate Degree – Nursing | <input type="checkbox"/> Doctoral Degree – Nursing (DNP) |
| <input type="checkbox"/> Baccalaureate Degree – Nursing | |

B. What is your highest level of education?

- | | |
|---|---|
| <input type="checkbox"/> Vocational / Practical Certificate Nursing | <input type="checkbox"/> Master's Degree – Nursing |
| <input type="checkbox"/> Diploma – Nursing | <input type="checkbox"/> Master's Degree – Non-Nursing |
| <input type="checkbox"/> Associate Degree – Nursing | <input type="checkbox"/> Doctoral Degree – Nursing (PhD) |
| <input type="checkbox"/> Associate Degree – Non-Nursing | <input type="checkbox"/> Doctoral Degree – Nursing Practice (DNP) |
| <input type="checkbox"/> Baccalaureate Degree – Nursing | <input type="checkbox"/> Doctoral Degree – Nursing Other |
| <input type="checkbox"/> Baccalaureate Degree – Non-Nursing | <input type="checkbox"/> Doctoral Degree – Non-Nursing |

C. Year of initial U.S. Licensure: _____



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- D. Country of entry-level education: _____
- E. What is your employment status?
- Actively employed in nursing or in a position that requires a nurse license (select one):
 - Full-time
 - Part-time
 - Per diem
 - Actively employed in a field other than nursing (select one):
 - Full-time
 - Part-time
 - Per diem
 - Working in nursing only as a volunteer
 - Unemployed (select one)
 - Seeking work as a nurse
 - Not seeking work as a nurse
 - Retired
- F. In how many positions are you currently employed as a nurse?
- 1
 - 2
 - 3 or more
- G. How many hours do you work during a typical week in all your nursing positions?
- | | | |
|--------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> <10 hours | <input type="checkbox"/> 31-40 hours | <input type="checkbox"/> >60 hours |
| <input type="checkbox"/> 11-20 hours | <input type="checkbox"/> 41-50 hours | |
| <input type="checkbox"/> 21-30 hours | <input type="checkbox"/> 51-60 hours | |
- H. Indicate the zip code, city, state, and county of your primary employer.
- Zip Code: _____
City: _____
State: _____
County: _____
- I. Identify the type of setting that most closely corresponds to your nursing practice position.
- | | |
|--|--|
| <input type="checkbox"/> Ambulatory Care Setting | <input type="checkbox"/> Nursing Home / Extended Care |
| <input type="checkbox"/> Assisted Living Facility | <input type="checkbox"/> Occupational Health |
| <input type="checkbox"/> Community Health | <input type="checkbox"/> Policy / Planning Regulatory / Licensing Agency |
| <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Dialysis Center | <input type="checkbox"/> School Health Services |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> School of Nursing |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospital | |
| <input type="checkbox"/> Insurance Claims / Benefits | |
- J. Identify the position title that most closely corresponds to your nursing practice position.
- | | |
|---|---|
| <input type="checkbox"/> Advanced Practice Registered Nurse | <input type="checkbox"/> Nurse Manager |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Nurse Researcher |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Staff Nurse |
| <input type="checkbox"/> Nurse Executive | <input type="checkbox"/> Other – Health Related |
| <input type="checkbox"/> Nurse Faculty / Educator | <input type="checkbox"/> Other – Non-Health Related |
- K. Identify the employment specialty that most closely corresponds to your nursing practice position:
- | | | |
|--|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Acute Care/ Critical Care | <input type="checkbox"/> Adult Health | <input type="checkbox"/> Anesthesia |
|--|---------------------------------------|-------------------------------------|



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- | | | |
|--|--|--|
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Medical / Surgical | <input type="checkbox"/> Psychiatric/Mental Health/ Substance Abuse |
| <input type="checkbox"/> Community | <input type="checkbox"/> Neonatal | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Emergency / Trauma | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Family Health | <input type="checkbox"/> Neurology / Neurosurgical | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Occupational Health | <input type="checkbox"/> School Health |
| <input type="checkbox"/> Geriatric / Gerontology | <input type="checkbox"/> Oncology | <input type="checkbox"/> Urologic |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Informatics | <input type="checkbox"/> Palliative Care / Hospice | <input type="checkbox"/> Other – Clinical Specialties |
| <input type="checkbox"/> Information Technology | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Other – Non-Clinical Specialties |
| <input type="checkbox"/> Maternal-Child Health / Obstetrics | <input type="checkbox"/> Perioperative | |
| | <input type="checkbox"/> Primary Care | |

L. What percent of your current position involves direct patient care?

- | | | |
|------------------------------|------------------------------|-------------------------------|
| <input type="checkbox"/> 0% | <input type="checkbox"/> 50% | <input type="checkbox"/> 100% |
| <input type="checkbox"/> 25% | <input type="checkbox"/> 75% | |

M. If unemployed, please indicate the reasons:

- | | |
|---|---|
| <input type="checkbox"/> Difficulty in finding a nursing position | <input type="checkbox"/> School |
| <input type="checkbox"/> Disabled | <input type="checkbox"/> Taking care of home and family |
| <input type="checkbox"/> Inadequate Salary | <input type="checkbox"/> Other |

N. Formal Education:

- I am not taking courses toward an advanced degree in nursing
- I am currently taking courses toward an advanced degree in nursing

O. Do you intend to leave / retire from nursing practice in the next 5 years?

- Yes
- No

P. List other states in which you have ever held a license:

Active License: _____

Inactive License: _____

Q. List all states where you are currently practicing nursing, whether physically or electronically: _____

Affidavit

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature of Applicant _____ Date _____



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Verification of Employment

To obtain/retain active licensure, a nurse must provide verification of a minimum of 140 hours in a 12-month period OR 480 hours in six years of employment/volunteer work in nursing.

Applicant:

- Complete the top section of this form then forward to your employer or former employer.
- This form may be duplicated for additional employment verifications.
- Return completed form(s) via email (sdbon@state.sd.us) or mail to the South Dakota Board of Nursing.

Please Print

Name (First): _____ (Middle): _____ (Last): _____

License Number: _____ SSN: _____

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for licensure purposes.

Signature of Applicant

Date

This Section to be Completed by Current or Previous Employer

Note: This section cannot be Signed by the Applicant

The above-named individual is/was employed/volunteered as a nurse (check one):

A minimum of 140 hours in a 12-month period during the previous 6 years

A minimum of 480 hours during the previous 6 years

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purpose of licensure is true and correct.

Signature of Agency Representative/Title

Date

Who can verify/confirm number of hours employed/volunteered

Name of Employer: _____

Address of Employer: _____

Telephone: _____ Email: _____