



# South Dakota Board of Nursing

4305 S. Louise Ave., Suite 201; Sioux Falls, SD 57106-3115  
605-362-2760 <https://www.sdbon.org/>

## CNA and RMA Complaint Form

This is the prescribed form for filing a complaint on a certified nursing aide (CNA), registered medication aide (RMA), or applicant, with the South Dakota Board of Nursing (SDBON).

Completion of this form is required pursuant to [SDCL § 36-1C-2](#): “Any person claiming that a licensee or an applicant for a license under Title 36 has engaged in or is engaging in conduct constituting grounds for disciplinary action, as enumerated in the laws or rules of the agency, may file with the agency a written complaint. The agency shall require the complaining party to file a complaint stating the name of the applicant or licensee against whom the complaint is made and set out, in full detail, the conduct that is alleged to be in violation and may prescribe the form on which a written complaint is made. Failure of the complainant to comply with this section is basis for the administrator to reject the complaint without further action.”

Pursuant to [SDCL § 36-1C-3](#), the Board must send a copy of this properly submitted complaint to the individual who is being complained against.

To submit a complaint, complete and sign this form; attach copies of pertinent documents and medical records if available, do not submit original documents. Send to:

SD Board of Nursing  
Attention: Sarah Nussbaum  
4305 S. Louise Ave Suite 201, Sioux Falls, SD 57106

Or email to: [sarah.nussbaum@state.sd.us](mailto:sarah.nussbaum@state.sd.us).

**A. Complainant(s) Information:** You may be contacted if more information is needed.

As the person(s) completing or contributing to this written complaint, enter your information:

1. First Name: \_\_\_\_\_
2. Last Name: \_\_\_\_\_
3. Address: \_\_\_\_\_
4. Phone Number: \_\_\_\_\_
5. Email Address: \_\_\_\_\_

**B. Registrant/Applicant Information** for the person against whom this complaint is being made:

1. First Name: \_\_\_\_\_
2. Last Name: \_\_\_\_\_
3. Registration #, if known: \_\_\_\_\_
4. Place of employment at time of alleged conduct: \_\_\_\_\_
5. Current place of employment, if known: \_\_\_\_\_



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### C. Complaint Information:

1. Were you the person for whom care was provided?

Yes

No, enter information on the person whom care was provided:

a. Full name: \_\_\_\_\_

b. Date of birth: \_\_\_\_\_

c. Relationship of person to you: \_\_\_\_\_

2. Do you represent the employer of the nurse involved?

No

Yes, enter employer information:

a. Employer name: \_\_\_\_\_

b. Employer contact information: \_\_\_\_\_

c. Has Registrant/Applicant had prior warnings/disciplinary action?  Yes  No

d. Please attach copies of employee history, evaluations, etc., as appropriate.

3. Have you contacted the Registrant/Applicant or the Registrant/Applicant's employer about your complaint?

No  Not applicable

Yes, describe what action, if any, was taken or is being taken?

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4. Has this complaint been filed elsewhere?

No

Yes, enter the name of the organization or agency:

What action, if any, is being taken or was taken?:

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