



SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 S Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ FAX: 362-2768 ♦ doh.sd.gov/boards/nursing

LPN EXAMINATION APPLICATION

There are separate forms and three separate fees that you must submit to start the examination process:

1. SD Board of Nursing Application for Practical Nurse Licensure by Examination ([below](#)):
\$100 fee payable to the Board
2. NCLEX Examination Registration to [Pearson](#) Professional Testing: \$200 fee payable to NCLEX®
The NCLEX registration fee of \$200 is made payable to the NCSBN, not to the Board of Nursing. Refer to your NCLEX Candidate Bulletin for payment information. Do not send the NCLEX fee to the Board; the Board will not forward fees on your behalf.
3. Criminal Background Check:
 1. Pursuant to SDCL 36-9-97, [ARSD 20:48:03:01:01](#), [ARSD 20:48:05:01](#), [ARSD 20:48:03:01](#), [ARSD 20:48:03:07](#), and [ARSD 20:48:03:08](#) each applicant for initial licensure is required to submit a full set of fingerprints with completed application to obtain a state and federal criminal background check.
 2. Please contact the South Dakota Board of Nursing to request your criminal background check packet.
 3. The fingerprint cards you receive from the SDBON **must** be the cards you use for fingerprints, since specific agency data are pre-printed on them.
 4. Contact your local law enforcement agency for fingerprinting.
 5. Send to the SD Board of Nursing office your completed fingerprint cards and a separate check or money order payable to: South Dakota Division of Criminal Investigation (DCI).
 6. Your application will not be processed and/or temporary license will **not** be issued until your completed application **and** fingerprint cards are received.
 7. You will **not** receive a permanent license until the fingerprint results from the Federal Bureau of Investigation (FBI) are received by the Board, approximately 1-2 weeks.
 8. Cards will be rejected if bent, folded, tampered with, stained, smeared, or stapled. If rejected, you will be notified to resubmit your cards.

An application is null one year following the date that it was accepted by the Board. Fees are non-refundable.

NAME AND ADDRESS CHANGES: If your name changes, submit legal proof, such as a copy of a marriage certificate or court order, to the Board. The Board will change your NCLEX® registration information to reflect your new name. If a change occurs in any information after you submit your application, send written notification to the [Board](#) as soon as possible. The Board will also update your address, email, or telephone information upon written notification. The Board will send official notification of exam results and licensure to the applicant address found on the NCLEX registration unless notified in writing of an alternate address.

REQUEST FOR ACCOMMODATIONS: Candidates with disabilities requiring modification to their examination must provide written notification to the Board *prior to* NCLEX Examination Registration. Your letter must address the specific testing accommodations you require. You must also arrange for:

- A letter from your nursing school indicating what modifications were granted by the program, and
- A letter from an appropriate professional providing specific identification of a disability that would require accommodations.

ELIGIBILITY REQUIREMENTS: The applicant is responsible for requirements. The Board will determine eligibility after receipt of:

- Application for Licensure by Examination and all fees
- Results of Criminal Background Check
- **Graduate of South Dakota Nursing Program only** - [Certificate of Nursing Education](#) completed by your nursing program
- **Graduate of Nursing Program outside of South Dakota** - Official transcripts from your school's Registrar
- NCLEX Registration (as verified by the SD Board of Nursing)

When you have met all eligibility requirements, an Authorization to Test (ATT) will be issued by Pearson Professional Testing.

TESTING PERIOD: The ATT is valid for 90 days; no extension will be granted. Once you have received your ATT, the applicant is solely responsible to schedule the examination date with Pearson Professional Testing, following the instructions provided with the ATT notification. **The Board of Nursing does not schedule examinations.** The Board recommends that you provide an email address upon registration to allow for rapid delivery of ATT following the Board's declaration of NCLEX eligibility. If you do not have an ATT and require a review of your application package, please contact the [Board](#).

OFFICIAL NOTIFICATION: About ten business days after you have taken the NCLEX, results will be mailed to you by the Board. If you passed, your nursing license will accompany your NCLEX results. If you did not pass, you will receive a [Request to Reapply for Licensure by Examination](#) and a diagnostic profile to help you understand your performance on the NCLEX.

TEMPORARY PERMIT APPLICATION: **South Dakota law regulating nursing is mandatory.** It is illegal to practice as a nurse without a current license or a valid Temporary Permit. There is no provision in law to use the title "graduate nurse". A Temporary Permit requires use of the title Licensed Practical Nurse Applicant (LPN App). Temporary Permit is available only for a first-time NCLEX writer who has fulfilled eligibility requirements, is non-renewable, and valid for 90 days or until written notification of NCLEX testing results is received by the applicant. The ATT from Pearson Professional Testing and your Temporary Permit should be issued within days of each other, allowing you to practice under the Temporary Permit while you schedule and take your NCLEX exam.

Temporary Permit must be presented to your employer; such permits are issued for use in one specific facility only. Specific limitations on the scope of practice for LPN Applicants holding Temporary Permits are in place; review limitations on the face of your Permit carefully. Failure on the NCLEX terminates the right to practice nursing; those applicants failing the NCLEX must return the Temporary Permit to the South Dakota Board of Nursing. Residents of other [Nurse Licensure Compact](#) states are eligible to practice in South Dakota with a current nursing license issued by their state Board. No Temporary Permits to practice in South Dakota are issued to residents of other Compact States. See www.ncsbn.org.

EXAMINATION PREPARATION: National Council of State Boards of Nursing has extensive information on the NCLEX at www.ncsbn.org. For a better understanding of the computer adaptive examination, please review the provided information. NCSBN also sponsors an online review course for NCLEX candidates. Information on the online course is available at www.learningext.com.



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APPLICATION FEE
\$100

APPLICATION FOR PRACTICAL NURSE LICENSURE BY EXAMINATION

South Dakota is a member of the Nurse Licensure Compact; you are not eligible for nurse licensure in South Dakota if your primary state of residence is another [Compact State](#). Please see www.ncsbn.org for more information or for a current list of Compact States.

Falsification or omission of information may be used by the South Dakota Board of Nursing as a basis for disciplinary action.

Type or print clearly in black ink ▪ Provide all information ▪ Incomplete applications are returned ▪ Do not use initials or abbreviations

LAST NAME		FIRST NAME		MIDDLE NAME
MAIDEN NAME		OTHER LAST NAME(S)		BIRTH DATE: MONTH/DAY/YEAR
ADDRESS				EMAIL
CITY	STATE	ZIP	TELEPHONE ()	
SS#:	US CITIZEN: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	OTHER TELEPHONE ()	
ETHNICITY: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other				
HIGH SCHOOL: NAME, CITY, AND STATE				<input type="checkbox"/> DIPLOMA – YEAR:
				<input type="checkbox"/> GED – YEAR:
SCHOOL OF NURSING: NAME, CITY, AND STATE				DEGREE TYPE : <input type="checkbox"/> DIPLOMA PRACTICAL NURSING <input type="checkbox"/> OTHER:
DATE ENTERED:	DATE COMPLETED:	OR	ANTICIPATED DATE OF COMPLETION:	
Have you ever applied for Practical Nurse licensure by examination in another state?		<input type="checkbox"/> YES <input type="checkbox"/> NO	If “YES,” where? Please explain.	
Have you ever taken the NCLEX® -PN or other nurse licensure examination in any state?		<input type="checkbox"/> YES <input type="checkbox"/> NO	If “YES,” where? Please explain.	
DISCIPLINARY INFORMATION				
1. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communications with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.				<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Is there any pending criminal prosecution against you which would constitute a felony?				<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?				<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever 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 ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?				<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Have you ever been treated for abuse or misuse of any alcohol or chemical substance?				<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?				<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
For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and events. You must also send ALL supporting applicable documents.				
DECLARATION OF PRIMARY STATE OF RESIDENCE – AND – AFFIDAVIT				
<input type="checkbox"/> I declare that my primary state of residence (where I hold a driver’s license, pay taxes, and or/vote) is _____. This is my “home state” under the Nurse Licensure Compact and is my “declared fixed permanent and principal home for legal purposes.” - OR - <input type="checkbox"/> I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: _____				
I further declare and affirm under penalties of perjury that this application for nurse licensure in South Dakota has been examined by me, and, to the best of my knowledge and belief, is in all things true and correct.				
Applicant Signature: _____				Date: _____



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APPLICATION FEE
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REQUEST TO REAPPLY FOR PRACTICAL NURSE LICENSURE BY EXAMINATION

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ETHNICITY: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other					
HIGH SCHOOL: NAME, CITY, AND STATE				<input type="checkbox"/> DIPLOMA – YEAR:	
				<input type="checkbox"/> GED – YEAR:	
SCHOOL OF NURSING: NAME, CITY, AND STATE				DEGREE TYPE :	
				<input type="checkbox"/> DIPLOMA PRACTICAL NURSING	
DATE ENTERED:		DATE COMPLETED:		OR ANTICIPATED DATE OF COMPLETION:	
				<input type="checkbox"/> OTHER:	
Have you ever applied for Practical Nurse licensure by examination in another state?		<input type="checkbox"/> YES <input type="checkbox"/> NO		If "YES," where? Please explain.	
Have you ever taken the NCLEX®-PN or other nurse licensure examination in any state?		<input type="checkbox"/> YES <input type="checkbox"/> NO		If "YES," where? Please explain.	
DISCIPLINARY INFORMATION					
1. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communications with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.					<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Is there any pending criminal prosecution against you which would constitute a felony?					<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?					<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever 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 ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?					<input type="checkbox"/> YES <input type="checkbox"/> NO
7. Have you ever been treated for abuse or misuse of any alcohol or chemical substance?					<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?					<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
For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and events. You must also send ALL supporting applicable documents.					
DECLARATION OF PRIMARY STATE OF RESIDENCE – AND – AFFIDAVIT					
<input type="checkbox"/> I declare that my primary state of residence (where I hold a driver's license, pay taxes, and or/vote) is _____. This is my "home state" under the Nurse Licensure Compact and is my "declared fixed permanent and principal home for legal purposes." - OR - <input type="checkbox"/> I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: _____					
I further declare and affirm under penalties of perjury that this application for nurse licensure in South Dakota has been examined by me, and, to the best of my knowledge and belief, is in all things true and correct.					
Applicant Signature: _____				Date: _____	

CERTIFICATE OF NURSING EDUCATION
(South Dakota Nursing Programs Only)

**This certificate is to be completed in black ink and signed
by the Director of the School of Nursing
from which the applicant graduated.**

Graduate: _____ SS# _____

Nursing Program _____
STATE NAME OF NURSING PROGRAM CITY

Admission Date ____/____/____

Completion / Graduation Date ____/____/____

**The program included theory
and clinical experience in:**

- Adult Health Nursing
- Maternal Child Nursing
- Geriatric Nursing
- Mental Health Nursing
- Psychiatric Nursing
- Community Health Nursing
- Other

Was the nursing program state-approved
when the applicant graduated? Yes No

Was high school completion verified? Yes No
If yes, by what means?
 High School Diploma
 GED

Degree granted:

- Diploma/Certificate in Practical Nursing
- Associate Degree in Nursing
- Diploma in Nursing
- Baccalaureate in Nursing
- Other: _____

*I hereby certify that the foregoing statements are
correct as shown on the records of the above
named individual on file in the school of nursing.
I recommend her (him) for examination and
State Licensure.*

**PLACE
SCHOOL SEAL
HERE**

SIGNATURE OF DIRECTOR OR DEAN OF NURSING PROGRAM

DATE

FOR BOARD USE ONLY
License Number _____
Date Licensed _____
Date(s) Written _____

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