South Dakota Board of Nursing
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

Certified Nurse Midwife
General Instructions for Licensure Application

Please follow instructions carefully to avoid delays in processing your application. If any of the information on your application is incorrect, incomplete or illegible, processing of the application may be delayed. You can expect that it will take 4 – 6 weeks before all forms are received by the Board office; upon receipt of all forms your application will be considered for approval. You will be notified in writing if additional information is required or that your application has been approved.

❑ Application and Fees

1. Complete general application Form 1 and return to South Dakota Board of Nursing office.
2. The fee for licensure is $100 and must accompany the application. Fee payment should be in the form of a money order or personal check made payable to South Dakota Board of Nursing. Fees are non-refundable. If a Temporary Permit is also desired, see Temporary Permit application instructions below.

❑ Registered Nurse License

1. You must have a current, valid, unencumbered South Dakota RN license or temporary permit.
   - If not, complete RN Application for Licensure by Endorsement available from the Board of Nursing website.
2. *Or* – provide a copy of your current, valid, unencumbered compact RN license from your primary state of residence (where you hold a driver's license, pay taxes, and/or vote).
   - South Dakota is a member of the Nurse Licensure Compact. For more information on the Nurse Licensure Compact see www.ncsbn.org.

❑ Request for Transcript Form

1. Complete Transcript Request Form 2 and send to the Office of the Registrar for each applicable college, university, or program which awarded you a graduate nursing degree or post graduate certificate which prepared you for your advanced nursing specialty role.
2. The transcript(s) must evidence the degree conferred and the date.
3. The official transcript(s) must be sent directly to the Board office from the college, university, or program. Copies of transcripts are not accepted.
4. Contact the Registrar's Office/Organization to determine the appropriate fee to enclose for transcript/document service.

❑ Education Verification

1. You complete applicant section of Education Verification Form 3; send a copy to each applicable college, university, or program from which you were awarded a graduate or post graduate certificate nursing degree.
2. The Dean/Director or designated official of the program completes the remaining questions verifying education and accreditation status of the nursing program at the time of your attendance.
3. The Dean/Director or designated official of the program must return completed Form 3 to the Board office.

Continues

❑ Certification Verification

Primary source verification of *successfully passing a standardized qualifying certification examination* specific to your area of practice or evidence of *current certification* from a Board-approved certification organization is required for licensure and renewal in South Dakota. The American Midwifery Certification Board (formerly known as American College of Nurse Midwives) is the Board-approved certification organization.

1. Applicant completes top section of Certification Verification Form 4; forward to your certifying organization.
2. Contact certifying organization to determine the appropriate fee to enclose.
3. The certifying organization will return the completed form directly (primary source) to the South Dakota Board of Nursing Office.

❑ CNM / CNP Advance Practice Nursing Functions

Licensure as a nurse practitioner or nurse midwife permits the licensee to practice advance practice nursing functions as defined in SDCL 36-9A-13.1 which reads as follows:

The nurse practitioner or nurse midwife advanced practice nursing functions include:

1. Providing advanced nursing assessment, nursing intervention, and nursing case management;
2. Providing advanced health promotion and maintenance education and counseling to clients, families, and other members of the health care team;
3. Utilizing research findings to evaluate and implement changes in nursing practice, programs and policies; and,
4. Recognizing limits of knowledge and experience, planning for situations beyond expertise, and consulting with or referring clients to other health care providers as appropriate.

❑ Overlapping Scope of Advanced Practice Nursing and Medical Functions

The CNM may perform the overlapping scope of advanced practice nursing and medical functions only under terms defined in a Collaborative Agreement with a physician licensed in South Dakota. *The collaborative agreement must be filed and approved by the Joint Board of Nursing & Medical and Osteopathic Examiners (Joint Boards) prior to performing the overlapping scope of advance practice nursing and medical functions.* Once the collaborative agreement has been reviewed and approved by the Joint Boards, it remains in effect until a new collaborative agreement is submitted. Collaborative agreement renewal is not required with licensure renewal, as long as the terms defined in the agreement describe current practice. Requests to modify functions described in SDCL 36-9A-13 (see below) must be submitted for Board review and approval prior to implementing the modifications.

❑ *CNM* Overlapping Scope of Advanced Practice Nursing & Medical Functions

According to SDCL 36-9A-13 the **CNM** may perform the following overlapping scope of advanced practice nursing and medical functions including:

1. Management of the prenatal and postpartum care of the mother-baby unit;
2. Management and direction of the birth;
3. Provision of appropriate health supervision during all phases of the reproductive life span to include family planning services, menopausal care, and cancer screening and prevention; and
4. Prescription of appropriate medications and provision of drug samples or a limited supply of appropriate labeled medications for individuals under the nurse midwife's care pursuant to the scope of practice defined in this section, including controlled drugs or substances listed on Schedule II in Chapter 34-20B for one period of not more than thirty days. Medications or sample drugs provided to patients shall be accompanied with written administration instructions and appropriate documentation shall be entered in the patient's medical record.

Continues

❑ Temporary Permit

To practice as a CNM in South Dakota, you must possess a temporary permit or license issued by the Joint Boards authorizing your practice. A temporary permit is required before you can begin orientation at your place of employment. A temporary permit is valid only for the period of time it has been issued and may not be renewed. Practice beyond the expiration date is a violation of law and may result in disciplinary action. The holder of a temporary permit to practice will use the designation of **CNM-app.** after name.

1. A **temporary permit by examination** is issued to an applicant waiting for results of the first exam they are eligible to take after completion of an approved education program. The temporary permit will be issued when the following is completed and received in the Board office:
   a. General Application – Form 1 with $100 fee.
   b. Temporary Permit Application – Form 5 with $25 fee.
   c. Verification of RN licensure: if you hold a "compact" RN license, other than SD, provide copy of license.
   d. Verification of education:
      Letter from nursing education program Dean/Director verifying completion of all program requirements *and* eligibility to sit for a national certification exam specific to specialty.
      – OR –
      Transcript verifying degree was conferred.
   e. Verification of examination eligibility:
      Documentation from certification organization that you are a candidate for the exam.
      – OR –
      Documentation from certification organization that you are awaiting results of first exam for which you are eligible after graduation.
   f. Submit Supervisory Agreement with a physician licensed in South Dakota to obtain approval to perform overlapping scope of advanced practice nursing and medical functions. The Supervisory Agreement becomes invalid upon issuance of a permanent license, at which time a Collaborative Agreement approved by the Joint Boards must be on file with the South Dakota Board of Nursing office.

2. A **temporary permit by endorsement** is issued to an applicant who holds licensure as a CNM in another state or territory and is awaiting licensure in South Dakota. The permit becomes invalid *120 days* from issuance date. The temporary permit will be issued when the following is completed and received in the Board office:
   a. General Application – Form 1 with $100 fee.
   b. Temporary Permit Application – Form 5 with $25 fee.
   c. Verification of RN licensure: if you hold a "compact" RN license, other than SD, provide copy of license.
   d. Verification of certification: Provide a copy of your current certification card from the certification organization – OR – Primary source verification of current certification on file with the Board sent by certification organization (See Form 4 below).
   e. Verification of current licensure: Provide copy of current CNM license from another state or territory.
   f. Submit Collaborative Agreement for Joint Board review and approval to perform overlapping scope of advanced practice nursing and medical functions.

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Certified Nurse Midwife
General Application – Form 1

Please Print

1. Name: First_____ Middle_____ Last _____

1. Other names previously used:_____

2. Address:_____ City_____ State_____ Zip_____
   Street/PO Box

3. Telephone: Home: ( )_____ Other: ( )_____ Email: _____

4. Date of Birth:_____ Place of Birth:_____ Social Security #: _____

5. US Citizen: ❑Yes ❑No Gender: ❑Male ❑Female

6. Ethnicity: ❒Caucasian ❒Black ❒Hispanic ❒Asian/Pacific Islander ❒American Indian/Alaskan Native ❒Other

7. Have you been licensed as a CNM in another state? ❑Yes (complete Question 7) ❑No

8. Advanced practice licensure history:

State	Licensed as	License #	Date Issued	Expiration Date

9. Information regarding your professional nursing education that prepared you for nursing specialty:

Institution Name	Location (City, State)	Completion Date	Program Type
			❑Certificate ❑Master's ❑Post-Master's
			❑Certificate ❑Master's ❑Post-Master's
			❑Certificate ❑Master's ❑Post-Master's

10. Do you hold current certification from a national certifying organization?
    ❑Yes (complete Question 11) ❑No ❑Awaiting exam results from American Midwifery Certification Board

11. Information regarding your certification from a national certifying organization:

Certification Organization	Specialty	Certification #	Date Issued	Expiration Date

12. Declaration of Primary State of Residence:

❑ 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 –

❑ I am employed by the federal government and so am not affected by Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer:_____

RN License # in primary state of residence if other than South Dakota:_____

_____ _____

Applicant Signature Date

13. If you hold a "compact" RN license, other than SD, provide a copy of that RN license.

14. 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 communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.**	❒YES	❒NO
2.	Is there any pending criminal prosecution against you which would constitute a felony?	❒YES	❒NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	❒YES	❒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?	❒YES	❒NO
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	❒YES	❒NO
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	❒YES	❒NO
7.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	❒YES	❒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?	❒YES	❒NO
9.	Do you currently owe child support arrearages in the sum of $1,000 or more?	❒YES	❒NO
For 2-9 above, provide explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.			

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.

_____ _____

Applicant Signature Date

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Transcript Request – Form 2

Applicant, please complete this form for each applicable college, university, or program that awarded you a graduate nursing degree or post graduate certificate which prepared you for your advanced nursing specialty role. Forward this form to the Office of the Registrar.

Please Print

1. Name: First_____Middle_____Last _____
2. Other names previously used:_____
3. Address: Street/PO Box _____City_____State_____Zip_____
4. Date of Graduation:_____ Social Security #:_____

I am requesting an official transcript (must bear raised or color coded school seal and evidence of the degree conferred and date conferred) of my nursing education be attached to this request and forwarded to the South Dakota Board of Nursing for licensure purposes.

_____ _____
Applicant Signature Date

Registrar:
Please return this form with the official transcript and
send to the South Dakota Board of Nursing at the address above.

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Certified Nurse Midwife
Education Verification – Form 3

Applicant, complete items 1 – 6 on this form then forward to the Dean/Director for each nursing college, university, or program which prepared you for your nursing specialty role.

Please Print

1. Graduate Name: First_____Middle_____Last_____
2. Other names previously used:_____
3. Address:_____City_____State_____Zip_____
   Street/PO Box
4. Telephone: Home: (___)_____ Other: (___)_____ Email: _____
5. Date of Birth:_____ SS#: _____
6. Consent to *Release Information* to the South Dakota Board of Nursing:
   - I have applied to the South Dakota Board of Nursing for a license to practice as a Certified Nurse Midwife. After completing all program requirements, please complete this form and forward directly to the South Dakota Board of Nursing office for licensure purposes.

_____ _____
Applicant Signature Date

Program Director: After completed, forward to the South Dakota Board of Nursing at the address above.

7. University/Institution Name_____Location (City, State)_____
8. Program Graduation/Completion Date: _____
   At the time the Applicant graduated, the graduate nursing program was accredited by:
   - ❑ American College of Nurse Midwives, Division of Accreditation
   - ❑ National Association of Nurse Practitioners in Women's Health, Council on Accreditation
   - ❑ Commission on Collegiate Nursing Education
   - ❑ NLN/National League for Nursing Accrediting Commission ❑ Other:_____
9. Type of Program (check one): ❑Certificate ❑Master's Degree ❑Post-Master's Certificate
10. Advanced role & specialty Applicant was educated in: ❑CNM ❑Other_____

_____ _____
Dean/Director Signature *or* Other Designated Official/Title Date

Place School Seal Here

If School Seal is no longer available, use either Agency/Institutional Seal, or so indicate.

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CERTIFICATION VERIFICATION – FORM 4

Applicant, complete items 1 – 8 on this form, then forward to certification organization.

Please Print

1. Name: First_____ Middle_____ Last _____
2. Other names previously used:_____
3. Address:_____ City_____ State_____ Zip_____
   Street/PO Box
4. Name of Certification Organization_____
5. Certification #_____ Expiration Date: _____
6. Certification status (check one): ❑ Initial certification verification ❑ Recertification verification
7. Certification type (check one): ❑ CRNA ❑ CNS ❑ CNM ❑ CNP
8. Consent to *Release Information* to the South Dakota Board of Nursing:

   I authorize the above-named certification organization to disclose information regarding the identification, evaluation, and certification of the above-named applicant that is maintained by the above-named certification organization to the South Dakota Board of Nursing. I authorize the South Dakota Board of Nursing to utilize this information as needed for validation, investigation, litigation, discipline, or agreements concerning my nursing license. This authorization to release requested information shall expire at my written request. A copy of this request shall be as effective as the original.

_____ _____
Applicant Signature Date

Certification Organization: complete below then forward to South Dakota Board of Nursing at address above.

NAME OF CERTIFICATION ORGANIZATION_____	
Certification #	**Date of Current Certification Maintenance Cycle/Recertified through:**
Certification type: ❑CNM ❑CNS – specialty area_____ ❑CRNA ❑CNP – specialty area_____	
Is certification current? ❑YES ❑NO (Please explain on a separate paper)	Has certification lapsed? ❑YES (Please explain on a separate paper) ❑NO
Has certification been revoked? ❑YES (Please explain on a separate paper) ❑NO	Is certification provisional/conditional in any manner? ❑YES (Please explain on a separate paper) ❑NO
_____ / _____ Name/Signature of person completing form Title	_____ Date

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Certified Nurse Midwife
Temporary Permit Application – Form 5

Please Print

1. Name: First_____Middle_____Last _____

2. Title for which you seek temporary permit: ❑ **CNM – app.**

3. Check type of temporary permit you are requesting:

❑ I am requesting a **temporary permit by examination**:

Name of Certification Organization	Exam Specialty Area	Date Exam Written — Or— Date Expected to Write Exam	Date Results Received/ Date Results Expected

❑ I am requesting a **temporary permit by endorsement**.
I currently hold a CNM license in another state or territory.

4. List information about each facility where you will be practicing on this temporary permit:

Name of Organization	Address (street address, city, state, zip)	Telephone Number(s)

5. Name of physician(s) with whom you will be ***collaborating*** on this ***permit by endorsement*** or with whom you have ***supervision*** from on this ***permit by examination***.

Name of Physician	Address (street address, city, state, zip)	Telephone Number(s)

I, the undersigned, declare and affirm under the penalties of perjury that this application for temporary permit 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.

_____ _____
Applicant Signature **Date**

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4305 S. Louise Avenue Suite 201
Sioux Falls, SD 57106-3115
(605) 362-2760 ◆ Fax: 362-2768 ◆ www.nursing.sd.gov

Certified Nurse Midwife Collaborative Agreement

THIS AGREEMENT, made this _____ day of _____, 20____, by and between

_____, hereinafter referred to as physician, and

_____, hereinafter referred to as Certified Nurse Midwife (CNM),

WITNESSETH:

Whereas, the Parties have developed a plan provided for under SDCL Chapter 36-9A whereby certain professional services may be performed by a qualified, licensed CNM in compliance with educational and training requirements, pursuant to SDCL 36-9A as administered by the South Dakota Board of Nursing and the South Dakota Board of Medical and Osteopathic Examiners, hereinafter referred to as Boards,

Whereas, performance of the overlapping scope of advanced practice nursing and medical functions requires licensure as a CNM and furthermore that such services shall be performed in collaboration with a physician, as defined in SDCL 36-9A-17,

Whereas, the Boards recognize the following nationally recognized documents to describe standards of practice and entry-level competencies for the practice of the CNM,

- *American College of Nurse-Midwives: Core Competencies for Basic Midwifery Practice* (May 2002, Revised June 2004). Silver Spring, MD: American College of Nurse-Midwives. http://www.acnm.org/education.cfm?id=331
- *Standards for the Practice of Midwifery* (March 2003). Silver Spring, MD: American College of Nurse-Midwives. http://www.acnm.org/education.cfm?id=331

And Whereas, the CNM is licensed to practice and manage care for women with focus on pregnancy, childbirth, post partum period, and gynecologic needs, care of the newborn, and family planning.

NOW, THEREFORE, IT IS AGREED BY AND BETWEEN THE PARTIES HERETO:

A. The CNM may perform such services as are allowed by SDCL 36-9A-13 and other tasks authorized by the Boards and not expressly excluded by SDCL Chapter 36-9A for which educational and clinic competency has been demonstrated in a manner satisfactory to said Boards, pursuant to SDCL 36-9A-13 and 36-9A-15.
   1. Management of the prenatal and postpartum card of the mother-baby unit;
   2. Management and direction of the birth;
   3. Provision of appropriate health supervision during all phases of the reproductive life span to include family planning services, menopausal care, and cancer screening and prevention; and,
   4. Prescription of appropriate medications and provision of drug samples or a limited supply of appropriate labeled medications for individuals under the nurse midwife's care pursuant to the scope of practice defined in this section, including controlled drugs or substances listed on Schedule II in chapter 34-20B for one period of not more than thirty days. Medications or sample drugs provided to patients shall be accompanied with written administration instructions and appropriate documentation shall be entered in the patient's medical record.

   Pursuant to SDCL 36-9A-17.1, parties may request modifications for approval by the Boards prior to performing. Boards base approval upon a finding of adequate collaboration, training, and proficiency.

   ❒ Modification Requested. *(Describe and attach additional documentation as needed)*_____

   _____

B. It is further understood and agreed by and between the parties:
   1. Definition of Collaboration: Pursuant to SDCL 36-9A-1(7), the act of communicating pertinent information or consulting with physician(s) licensed pursuant to Chapter 36-4, with each provider contributing their respective expertise to optimize the overall care delivered to the patient.
   2. The term *direct personal contact*, pursuant to ARSD 20:62:03:04, means that both the collaborating physician and the CNM are physically present on site and available for the purposes of collaboration.

3. Collaboration by *direct personal contact* between the CNM and the Physician must occur no less than twice each month unless a modification request is approved by the Joint Boards that one of the twice monthly meetings be held by telecommunication (ARSD 20:62:03:03).

❒ Modification Requested. *(Describe modification and rationale)*_____

4. Pursuant to ARSD 20:62:03:05, in addition to the required two meetings per month, the collaborating physicians must be physically present on-site every ninety days at each practice location. This requirement does not apply to locations where health care services are not routine to the setting, such as patient homes and school health screening events.
5. When the collaborating physician is not in direct personal contact with the CNM, the physician must be available by telecommunication (ARSD 20:62:03:04).
6. Nothing in this agreement shall be construed to limit the responsibility of either party to the other in the fulfillment of this agreement.
7. In the event the Boards put a restriction upon the services that may be performed by the CNM, the Physician hereby waives any objection to the CNM's failure to perform those tasks not permitted by said Boards.
8. Pursuant to SDCL 36-9A-17.2, the Boards will not approve any collaborative agreement that includes abortion as a permitted procedure.

C. Parties may request modifications for approval by the Boards prior to performing (SDCL 36-9A-15). The Boards base approval upon a finding of adequate collaboration, training, and proficiency pursuant to SDCL 36-9A-17.1.

❑ Modification Requested: *(attach additional documentation if needed)*_____

D. The CNM will work:

❑ Full-time: 100% FTE status ❑ Part-time: _____% FTE status

Pursuant to SDCL 36-9A-17.1 a physician may establish a collaborative relationship with up to four full-time equivalents (FTE).

E. The CNM will practice at the following practice site(s) in South Dakota:

Pursuant to ARSD 20:62:03:05 A CNM who practices at ***multiple practice sites*** *with the same collaborating physician shall collaborate by direct personal contact at one of the practice sites. To assure quality patient care where multiple practice sites are utilized, the Board of Medical &Osteopathic Examiners expects that the collaborating physician will collaborate at each of the sites on a regular basis throughout the year. Failure to demonstrate collaboration on a regular basis may constitute grounds for disciplinary action pursuant to SDCL 36-4-30 and 36-9A-29.*

- Facility Name: _____

Address _____ Phone _____ Fax _____

- Facility Name: _____

Address _____ Phone _____ Fax _____

- Facility Name: _____

Address _____ Phone _____ Fax _____

- Facility Name: _____

Address _____ Phone _____ Fax _____

F. The collaborative agreement shall not take effect until it has been completely executed between the Physician and the CNM outlining those activities which the CNM shall perform, shall be filed in the office of the State Board of Nursing and approved by the Joint Boards.

The agreement shall remain in effect as long as the terms defined herein describe the CNM's current practice unless terminated in writing by either party. Upon termination of this agreement, the CNM may not perform the services defined in SDCL 36-9A-12 unless a new or existing collaborative agreement is on file with the Boards. If such termination occurs, the CNM shall report the same to the Boards within ten (10) days of such termination.

It is further understood and agreed by and between the parties that any changes in the practice act subsequent to the date of this collaborative agreement will take precedence and modify the affected provisions(s) of this agreement.

THE PARTIES HERETO ENTER IN THIS AGREEMENT ON THE DATE AND YEAR FIRST WRITTEN ABOVE:

I, the undersigned, declare and affirm under the penalties of perjury that this Collaborative Agreement has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

I am aware that should I furnish any false information in this Collaborative Agreement, such an act may constitute cause for denial of approval and discipline of my license to practice in South Dakota.

Primary Collaborating Physician:

Print or Type Name	Signature	License #	Date

CNM:

Print or Type Name	Signature	License #	Date

Secondary Collaborating Physician(s):

If the primary collaborating physician is unavailable, or unable to meet the standard of collaboration with the CNP; the physician or physicians identified in this agreement as secondary physicians, have agreed to provide the required collaboration (SDCL 36-9A-17; ARSD 20:62:03:06).

Print or Type Name	Signature	License #	Date
Print or Type Name	Signature	License #	Date
Print or Type Name	Signature	License #	Date
Print or Type Name	Signature	License #	Date
Print or Type Name	Signature	License #	Date
Print or Type Name	Signature	License #	Date
Print or Type Name	Signature	License #	Date

Attach additional pages for additional secondary physicians if needed.

Mail agreement with original signatures to the South Dakota Board of Nursing:
4305 S. Louise Avenue, Suite 201; Sioux Falls, South Dakota 57106-3115.

Retain a copy of agreement for your records.
**** Must receive Joint Board approval prior to practice ****

To expedite the approval process you may choose to fax, 605-362-2768, or email (Linda.Young@state.sd.us) a pdf document to the Board of Nursing Office. *The original must be mailed to the Board of Nursing.*

The CNM will receive notice of approval status via postal service to their last known home address unless requested to receive notice by email. Others may also request notice of approval status by emailing Linda.Young@state.sd.us; notice will be sent by email.

JOINT BOARDS
SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

4305 S. Louise Avenue, Suite 201, Sioux Falls, South Dakota 57106-3115
Phone: 605-362-2760 Fax: 605-362-2768 www.state.sd.us/doh/nursing

NURSE MIDWIFE SUPERVISORY AGREEMENT

THIS AGREEMENT, made this _____ day of _____, 20_____, by and between _____ hereinafter referred to as physician, and _____, hereinafter referred to as Nurse Midwife, **WITNESSETH**:

Whereas, the Parties have developed a plan provided for under SDCL Chapter 36-9A whereby certain professional services may be performed by a qualified Nurse Midwife in compliance with educational and training requirements, pursuant to SDCL 36-9A, as administered by the South Dakota Board of Nursing and the South Dakota Board of Medical and Osteopathic Examiners, hereinafter referred to as Boards,

And Whereas, performance of the overlapping scope of advanced practice nursing and medical functions requires licensure as a Nurse Midwife, and furthermore that such services shall be performed under the supervision of the physician as supervision is defined in SDCL 36-9A-2.1.

NOW, THEREFORE, IT IS AGREED BY AND BETWEEN THE PARTIES HERETO:

A. The Nurse Midwife may perform such services as are allowed by SDCL 36-9A-13 and such other tasks authorized by the Boards and not expressly excluded by SDCL Chapter 36-9A for which educational and clinic competency has been demonstrated in a manner satisfactory to said Boards.

B. It is further understood and agreed by and between the parties:
   1. **The Nurse Midwife and Physician shall be subject to thirty days of on-site, direct supervision by the Physician. Thereafter the direct supervision shall include two one-half business days per week of on-site personal supervision by a supervising physician.**
   2. *In the event the Primary Physician is unable to supervise the Nurse Midwife; the physician or physicians identified in this agreement as secondary physicians, have agreed to provide secondary supervision.*
   3. Nothing in this agreement shall be construed to limit the responsibility of either party to the other in the fulfillment of this agreement.
   4. In the event the Boards puts a restriction upon the services that may be performed by the Nurse Midwife, as a condition precedent to licensure, the Physician hereby waives any objection to the Nurse Midwife failure to perform those tasks not permitted by said Boards.
   5. Pursuant to SDCL 36-9A-17.2, the Boards will not approve any supervisory agreement that includes abortion as a permitted procedure.

C. Parties may request modifications for approval by the Boards prior to performing (SDCL 36-9A-15). The Boards base approval upon a finding of adequate collaboration, training, and proficiency as described in SDCL 36-9A-17.1.

   ❑ No modification requested
   ❑ Modification(s) requested: *(Identify below)*

   _____

   _____

D. The Nurse Midwife will work: _____% FTE status (10, 20, 30, 40, etc. through 100% FTE)

E. The Nurse Midwife will practice at the following setting(s):

1. SD healthcare site: _____
Name
Address: _____ Phone Number: _____

2. SD healthcare site: _____
Name
Address: _____ Phone Number: _____

3. SD healthcare site: _____
Name
Address: _____ Phone Number: _____

4. SD healthcare site: _____
Name
Address: _____ Phone Number: _____

F. The Supervisory Agreement shall not take effect until it has been completely executed between the Physician and the Nurse Midwife outlining those activities which the Nurse Midwife shall perform, shall be filed in the office of the State Board of Nursing, and approved by the Joint Boards.

The agreement shall remain in effect until the temporary permit becomes invalid, unless terminated in writing by either party. If such termination occurs, the Nurse Midwife shall report the same to the Boards within ten (10) days of such termination.

The parties hereto enter in this agreement on the date and year first written above.

I, the undersigned, declare and affirm under the penalties of perjury that this Supervisory Agreement has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

I am aware that should I furnish any false information in this Supervisory Agreement, such an act may constitute cause for denial of approval and discipline of my license to practice in South Dakota.

Signature of Primary Supervising Physician	**Signature of Nurse Midwife**
_____	_____
Print or Type Name	Print or Type Name
_____	_____
Signature	Signature

Signature of Secondary Physician(s)

_____	/ _____
Print or Type Name	Physician Signature
_____	/ _____
Print or Type Name	Physician Signature
_____	/ _____
Print or Type Name	Physician Signature
_____	/ _____
Print or Type Name	Physician Signature
_____	/ _____
Print or Type Name	Physician Signature