



South Dakota Board of Nursing Facility Administrators

P.O. Box 340, 1351 N. Harrison Ave. Pierre, SD 57501-0340

Ph.: 605-224-1721

Fax: 888-425-3032

E-mail: SDNFA@midwestsolutionsd.com

<http://nursingfacility.sd.gov>

APPLICATION TO REACTIVATE LICENSE

Please submit the following:

1. Completed application;
2. Nonrefundable application fee of \$300 and \$100 state examination fee;
3. If applicable, a verification letter from each state in which you have been registered;
4. If applicable, verification of any name change; and
5. Verification of 20 hours of approved continuing education earned within the past 12 months.

Name: _____ E-mail: _____ Phone: _____

Address: _____ SSN: _____ DOB: _____

City: _____ State: _____ Zip: _____

Employer Office: _____ Phone: _____

Physical Address: _____ Mailing address: _____

City: _____ State: _____ Zip: _____

Inactive SD License: License #: _____ Year Inactivated: _____

Reason for request to reactive your license:

Please answer the following questions:

1. Are you the spouse of a member of the armed forces of the United States? Yes No
2. If yes, was your spouse the subject of a military transfer to South Dakota and did you leave employment to accompany your spouse to South Dakota? Yes No
3. Are you currently more than \$1,000 behind in child support payments? Yes No
 - a. *If yes, please attach documentation from the South Dakota Department of Social Services (DSS) of your arrangements with the DSS for payment of any accumulated arrearages.*
4. Do you currently hold a valid license issued by a different state or the District of Columbia to practice as a Nursing Facility Administrator? Yes No

If applicable, please submit the following information for each state in which you have been licensed. *You must also submit a certified letter verifying the license number and status of your license from the board of nursing facility administrators in each state in which you have been licensed. **These letters must be sent directly to our office.***

STATE _____	LICENSE # _____	DATE RECEIVED _____	STATUS _____
STATE _____	LICENSE # _____	DATE RECEIVED _____	STATUS _____

5. Do you practice as a Nursing Facility Administrator:

Full-Time	Part-Time	Temporary	Retired/Not Working
-----------	-----------	-----------	---------------------

<u>CRIMINAL HISTORY</u>		(circle one)	
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, or had prosecution deferred with respect to a felony? If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communications (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements. You must attach all communications for a violation to the signed and dated explanation of that violation. Please put correspondence in chronological order (most recent first). If you have more than one violation, please do the same for each violation.	Yes	No	
2. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 misdemeanor traffic offense?	Yes	No	
3. Is there any pending criminal prosecution against you?	Yes	No	
4. Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	Yes	No	
5. Has any license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, or have you been placed on probation or otherwise subjected to any type of disciplinary action?	Yes	No	
6. Have you ever been denied a license to practice in another state?	Yes	No	
7. Have you ever appeared or been requested to appear before any licensing board concerning any violation of law or regulation of any state district, territory or province of the United States or Canada?	Yes	No	
8. Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	Yes	No	
9. Have you ever been subject to proceedings by a professional society to revoke, reduce or restrict membership?	Yes	No	
10. Have you ever received care or treatment for abuse or misuse of alcohol or any chemical substance?	Yes	No	
11. Have you ever received care or treatment for an emotional or mental condition or illness?	Yes	No	
12. Do you currently owe child support arrearages in the amount of \$1,000 or more?	Yes	No	
13. Were you subject to any ethical violations while enrolled in school?	Yes	No	
14. Have you ever been released from the military by any means other than an honorable discharge?	Yes	No	
15. Are you in any way using fraud or deception in applying for a license to practice in South Dakota?	Yes	No	
For 2-15 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. You must attach supporting documents to the signed and dated explanation. Please put supporting documents in chronological order (most recent first).			

