SOUTH DAKOTA BOARD OF NURSING
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.nursing.sd.gov

Reinstatement for Lapsed Advanced Practice Nurse Licensure

Please follow instructions carefully to avoid delays in processing reinstatement of your CNM, CNP, CRNA, or CNS license. If any information is incorrect, incomplete or illegible, processing may be delayed. Upon receipt of all forms and fees your application will be considered for reinstatement. You will be notified in writing if additional information is required.

Your license(s) expire on your birth date. If not renewed by the expiration date, the license(s) lapse and must be reinstated prior to resuming practice.

Provisions in law relating to practice without a valid license:

SDCL 36-9A-29 - Revocation or suspension of license – Grounds
SDCL 36-9A-35 - Prohibited Acts (Class 1 Misdemeanor)
ARSD 20:62:02:07 Reinstatement of Lapsed Licenses
SDCL 36-9A-24 Reinstatement of Lapsed License
SDCL 36-9-49 - Grounds for denial, revocation or suspension of license, certification or application,
SDCL 36-9-68 - Prohibited Acts - Misdemeanor
SDCL 36-9-71 - Unlicensed practice of nursing as a public nuisance
ARSD 20:48:03:12 – Lapse and reinstatement License
SDCL 36-9-47 - Reinstatement of lapsed license or certificate -- Fee

To reinstate your CNM, CNP, CRNA, or CNS license you must be actively licensed as an RN.

- If South Dakota is your primary state of residence, or if you reside in a non-compact state, and your SD RN license is active you have met this requirement.
- If your South Dakota RN license has lapsed, you must Reinstate your South Dakota RN license.
- If you reside in a Compact State, and your RN license in that state is active, send a copy of that active RN license to be verified by the South Dakota Board of Nursing.

To REINSTATE your advanced practice nursing license, ***submit the following*** to the South Dakota Board of Nursing office at the address listed above:

- Completed Application for Reinstatement of Advanced Practice Nurse Lapsed License indicating license(s) to be reinstated.
- Completed Employment Verification Form
- Fee payment should be in the form of a money order or a personal check payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany form. A $20 fee will be charged for any insufficient check written.

Fees required to reinstate both South Dakota RN license and APN license: $90 RN renewal fee + $50 RN reinstatement fee + $70 APN renewal fee + $50 APN reinstatement fee= **$260**
Fees required to reinstate only South Dakota APN license: (South Dakota RN license is current): $70 APN renewal fee + $50 APN reinstatement fee= **$120**
Fee required to renew South Dakota APN license only (hold valid compact RN license with multi-state privileges): $70 APN renewal fee + $50 APN reinstatement fee= **$120**

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Application for Reinstatement of Advanced Practice Nurse Lapsed License

I request to REINSTATE each license checked:

☐ SD RN: License #(s): _____
☐ CNM: License #(s): _____
☐ CNP: License #(s): _____
☐ CRNA: License #(s): _____
☐ CNS: License #(s): _____

(Please Print)

The reason my license(s) lapsed is _____
Have you worked in South Dakota on this lapsed license? ☐ YES ☐ NO
If YES, where and when? _____

Name: First _____ Middle _____ Last _____

Other names previously used: _____

Address: _____
Street/PO Box City State Zip

Telephone: Home: (___) _____ Other: (___) _____ Email: _____

RN License: _____ _____
Number State Expiration Date Date of Birth

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 the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: _____

Collaborative Agreement Information (Applicable to CNM and CNP ONLY)

To perform the overlapping scope of advanced practice nursing and medical functions with a physician licensed in South Dakota as defined in SDCL 36-9A-12 and SDCL 36-9A-13, CNMs and CNPs must have on file a current Joint Board of Nursing and Medical and Osteopathic Examiners approved collaborative agreement (SDCL 36-9A-15 and SDCL 36-9A-17).

Collaborative Agreement renewal is not required with licensure renewal, as long as the terms defined in the agreement describe current practice. The CNP/CNM is accountable to maintain current status of all collaborative agreements on file with the Boards. Once a collaborative agreement has been reviewed and approved by the Boards, it remains in effect until a new collaborative agreement has been submitted and approved. To obtain a collaborative agreement, go to the Board of Nursing website at www.nursing.sd.gov, select Site Index then Collaborative Agreement.

- ❑ I do not have a collaborative agreement on file with the Boards. I do not perform the overlapping scope of advanced practice nursing and medical functions as defined in 36-9A-12 / 36-9A-13.
- ❑ I have included a new or revised collaborative agreement with this application to be approved by the Boards.
- ❑ I have an approved collaborative agreement(s) on file with the Boards. My **primary physician(s)** are listed below:

Primary Physician(s): _____

Certification Information

Primary source verification of *current* certification from a Board-approved certification organization specific to your area of practice is *required* to be on file with the Board office prior to your APN license being renewed. If you are unsure if you have current certification on file, contact the Board office. Photocopies of certification documents are not accepted.

- ❑ Primary source verification showing evidence of my current certification is already on file with the BON office. If so, you do not need to resubmit.
- ❑ I am a CRNA, AANA# _____. Primary source verification of your re-certification status will be monitored on NBCRNA's verification website.
- ❑ I do not have primary source verification of my certification on file with the BON, I have sent the Certification Verification Form to my certifying organization to be sent to the SD BON verifying my on-going currency of certification.
  - ○ CNPs or CNSs certified with NCC or ANCC must submit on-line requests to NCC and ANCC for primary source verification to be sent to the BON.
- ❑ I am exempt from certification requirement. I was originally licensed as a CNP/CNM in South Dakota before June 26, 1996 or as a CNS before July 1, 1996 and have never submitted certification evidence to the Board for licensure purposes.

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 an 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.

Employment Information: Select **ONE** response in each category below that best represents your current practice.

Employment Status:

- ☐ Full-time Nurse
- ☐ Part-time Nurse
- ☐ Full-time other than Nursing
- ☐ Part-time other than Nursing
- ☐ Volunteer Nurse
- ☐ Unemployed
- ☐ Retired

Principle Field/Place of Employment:

- ☐ Hospital
- ☐ Nursing Home/Long Term Care
- ☐ Nursing Education Program
- ☐ Home Health / Hospice
- ☐ School
- ☐ Outpatient Surgical Center
- ☐ Office / Clinic
- ☐ Community Health
- ☐ Self-Employed
- ☐ Other

Where Presently Employed:

County:

State:

City:

Zip Code:

Highest Degree Held:

- ☐ Diploma / Registered Nurse
- ☐ Associate Degree/RN
- ☐ Baccalaureate Degree/RN
- ☐ Baccalaureate in other field
- ☐ Masters in Nursing
- ☐ Masters in other field
- ☐ Doctorate (PhD, Ed, DNP)
- ☐ Practical Nurse Diploma/A.D.

Type of Position:

- ☐ Nurse Management
- ☐ Consultant
- ☐ Case Manager
- ☐ Nursing Program Faculty
- ☐ Clinic Nurse
- ☐ Staff Nurse
- ☐ Charge Nurse
- ☐ Inservice Educator/Staff Development
- ☐ Advanced Practice Nurse
  - ☐ CNM ☐ CNP
  - ☐ CRNA ☐ CNS
- ☐ Other

Formal Education Activities:

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

What percent of your current position involves direct patient care?

☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do you intend to leave/retire from nursing practice in the next 5 years? ☐ YES ☐ NO

States other than South Dakota in which you are licensed as a nurse:

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

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) to the South Dakota Board of Nursing.

To obtain/retain active status license, a nurse must provide verification of employment/volunteer work in nursing within the previous six years of at least 140 hours in any 12-month period OR an accumulated 480 hours.

Please Print

Name, First_____Middle_____Last _____

❒ I have been employed/volunteered as a nurse (LPN, RN, CRNA, CNM, CNP, or CNS).
❒ I have not been employed as a nurse within the last six years.

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 Employer
(Provide Employment Hours Within the Last 6 Years)
Note: This section Cannot be Signed by the Applicant

The above-named individual (was) employed/volunteered as a nurse

From _____
Month/Date/Year

To _____
Month/Date/Year

Total hours worked in this period:_____

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: _____

Certification Verification Form

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 ❑ CRNA ❑ CNS– specialty area_____ ❑ 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	