



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

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 (SD) Board of Nursing (BON) office.
2. The fee for licensure is \$100 and must accompany application. Fee payment should be in the form of a money order or check payable to SD Board of Nursing. Fees are non-refundable. If a Temporary Permit is also desired, see [Temporary Permit](#) 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 the license number of a compact RN license from your primary state of residence (where you hold a driver's license, pay taxes, and/or vote).
 - SD is a member of the Nurse Licensure Compact, for more information on the Nurse Licensure Compact see www.ncsbn.org.

Criminal Background Check

1. Pursuant to SDCL 36-9A-9.1 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. To request your criminal background check packet please contact the South Dakota Board of Nursing at (605) 362-2760 or email Jill.Vanderbush@state.sd.us
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. Contact your local law enforcement agency for fingerprinting.
4. Send to the SD Board of Nursing office your completed fingerprint cards and money order payable to: South Dakota Division of Criminal Investigation (DCI).
5. Your application will not be processed and/or temporary license will **not** be issued until your completed application **and** fingerprint cards are received.
6. 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.
7. Cards will be rejected if bent, folded, tampered with, stained, smeared, or stapled. If rejected, you will be notified to resubmit your cards.

Request for Transcript Form

Submit a transcript from each applicable college, university, or program that you attended and completed course work at for your nurse midwife role. The college that issued the degree must include the date the degree was conferred or awarded and the APRN role and population focus area you were prepared. You may choose to:

1. Complete the college's online transcript request process, have the transcript electronically sent directly to: Jill.Vanderbush@state.sd.us
2. OR – Complete the Transcript Request [Form 2](#) and send to the Office of the Registrar. Contact the Registrar's Office to determine the appropriate fee to enclose for transcript/document service. The Registrar must send the official transcript(s) directly to the SD BON office. (Copies of transcripts are not accepted.)

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 the completed [Form 3](#) to the Board office.



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Certification Verification

Primary source verification of successfully passing the nurse midwife certification examination offered by the [American Midwifery Certification Board](#) (AMCB) and maintaining current certification with the AMCB is required for licensure and renewal in SD. Refer to AMCB's website to request primary source verification of your certification status be sent directly to the Board office.

Practice Verification

Submit the Practice Verification [Form 4](#). All applicants for licensure are required to practice a minimum of 1,040 hours as a *licensed* CNM to practice without a collaborative agreement. *If you cannot verify 1,040 hours of licensed practice* you are required to submit a [Collaborative Agreement](#) with a SD licensed physician or SD licensed CNM.

Advance Practice Nursing Functions

Licensure as a nurse midwife permits the licensee to practice as defined in SDCL 36-9A-13 and 36-9A-13.1 which reads as follows:

36-9A-13. In addition to the registered nurse scope of practice, as defined in § 36-9-3, and within the certified nurse midwife role and population focus, a certified nurse midwife may perform the following advanced practice registered nursing scope:

- (1) Conduct an advanced assessment;
- (2) Order and interpret diagnostic procedures;
- (3) Manage the provision of women's health care throughout the lifespan, from adolescence through post menopause, including:
 - (a) Establishing primary and differential diagnoses;
 - (b) Managing prenatal care;
 - (c) Managing intrapartum care; and
 - (d) Managing postpartum care of the mother-baby unit;
- (4) Manage sexually transmitted infections in males;
- (5) Prescribe, order, administer, and furnish therapeutic measures as follows:
 - (a) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources;
 - (b) Prescribe, procure, administer, and furnish pharmacological agents, including over the counter, legend, and controlled drugs or substances listed on Schedule II in chapter [34-20B](#); and
 - (c) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services including home health care, physical and occupational therapy;
- (6) Complete and sign official documents such as death certificates, birth certificates, and similar documents required by law; and
- (7) Delegate and assign therapeutic measures to assistive personnel.

36-9A-13.1. The certified nurse practitioner or certified nurse midwife shall collaborate with other health care providers and refer or transfer patients as appropriate.

Temporary Permit

To practice as a nurse midwife in SD, you must possess a temporary permit or license issued by the Board of Nursing 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 his/her 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. Fingerprint cards (see [Criminal Background Check](#) above)
 - d. Verification of current RN licensure.
 - e. Verification of education – Completed [Form 3](#) or Transcript verifying degree was conferred.
 - f. Verification of examination eligibility: Documentation from AMCB that you are eligible to sit for their exam or that you are awaiting results of the first exam for which you are eligible after graduation.



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- g. Submit [Supervisory Agreement](#) with a SD licensed physician or SD licensed CNM. Applicants are required to be supervised the first 30 days by direct personal contact (physically present and available). Thereafter, and until the expiration of temporary permit, supervision must include two, one-half business days per week. Upon issuance of a permanent CNM license the Supervisory Agreement becomes invalid at which time a Collaborative Agreement must be on file.
 - h. Submit the [Collaborative Agreement](#) with a SD licensed physician or SD licensed CNM. New CNM licensure applicants are required to practice a minimum of 1,040 hours as a *licensed* CNM to practice without a collaborative agreement. Hours practiced on a temporary permit are not *licensed* CNM practice hours and cannot be included in the minimum 1,040 hours. (Once a licensee has met the minimum 1,040 hours of practice as a licensed CNM the licensee may complete the Practice Verification [Form 4](#) to request that the BON retire the Collaborative Agreement.)
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 SD. 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. Fingerprint cards (*see [Criminal Background Check](#) above*)
 - d. Verification of current RN licensure.
 - e. Verification of current CNM licensure.
 - f. Verification of current certification by AMCB in role of CNM. Provide a copy of your current certification card – OR – have primary source verification of current certification sent directly from AMCB to the Board office.
 - g. Submit Practice Verification [Form 4](#). Applicants are required to practice a minimum of 1,040 hours as a licensed CNM to practice without a collaborative agreement. *If you cannot verify 1,040 hours of licensed practice* complete and submit a [Collaborative Agreement](#) with a SD licensed physician or SD licensed CNM.



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Certified Nurse Midwife General Application – Form 1

Please Print

Name: First _____ Middle _____ Last _____

Other names previously used: _____

Home Address: _____ City _____ State _____ Zip _____
Street/PO Box

Telephone: Home: () _____ Cell: () _____ Other: () _____

Email: _____

Date of Birth: _____ **Place of Birth:** _____

Social Security #: _____ **US Citizen:** Yes No **Gender:** Male Female

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

1. Have you been licensed as a CNM in another state? Yes (complete question 2) No (skip to question 3)

2. Advanced practice licensure history:

State	Licensed as	License #	Date Issued	Expiration Date

3. Information regarding your RN and CNM nursing education:

Institution Name	Location (City, State)	Completion Date	Degree Received: (i.e. diploma, AD, BS, MS, Post Certificate, MS, DNP)

4. Primary source verification of passing the American Midwifery Certification Board's (AMCB) nurse midwife exam and maintaining current certification is required for initial licensure and renewal of license. Request primary source verification be sent directly to the SD BON office.

Do you hold current certification from AMCB?

Yes; certification number: _____

No:

I sat for the exam on: ____/____/____, and I am awaiting results from AMCB

I am scheduled to sit for the exam on: ____/____/____

I have applied to sit for the exam but do not have a test date yet

Primary source verification and maintaining current certification is required for initial licensure and renewal of license.



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5. 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.
- Provide RN License # in primary state of residence: _____

6. Are you employed by the federal government? Yes No

If yes, you are not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence.

7. Compliance Information:

1.	Have you been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, 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.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	<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 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 been treated for abuse or misuse of any alcohol or chemical substance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7.	Are you currently enrolled in an Alternative to Discipline Program?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8.	Have you experienced a physical, emotional, or mental condition that has endangered or posed a direct threat to the health or safety of persons entrusted to your care or your ability to safely practice?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9.	Do you currently owe child support arrearages in the sum of \$1,000 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 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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Certified Nurse Midwife **OPTIONAL Transcript Request – Form 2**

This form is optional. If the college offers online transcripts you may choose to request an online transcript be sent to the Board office. Request the transcript be electronically sent directly to: Jill.Vanderbush@state.sd.us

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 the top section of this form then forward to the Dean/Director of the nursing program that prepared you in the CNM role and focus area. (The nursing program should complete this form, not the Registrar.)

Please Print

Graduate Name: First _____ Middle _____ Last _____

Other names previously used: _____

Address: _____ City _____ State _____ Zip _____
Street/PO Box

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

Date of Birth: _____ SS#: _____

Name of Education Program: _____

Location of Program: (City, State) _____

Date your APRN degree was conferred/awarded? _____

Consent to Release Information to the South Dakota Board of Nursing:

I have applied to the SD Board of Nursing for a CNM license. Please complete this form and forward directly to the South Dakota Board of Nursing office for licensure purposes.

Applicant Signature _____ Date _____

Nursing Program Director: Complete items below and send to the South Dakota Board of Nursing at the address/fax number listed above or email PDF document to: Jill.Vanderbush@state.sd.us

1. The applicant was educated in the role of a CNM and completed the following type of program (check one):

- Certificate Master's Degree Post-Graduate Certificate DNP Other _____

2. At the time the Applicant graduated, the graduate nursing program was accredited by:

- Accreditation Commission for Education in Nursing (ACEN)
 American College of Nurse Midwives, Division of Accreditation (ACME)
 Commission on Collegiate Nursing Education (CCNE)
 National Association of Nurse Practitioners in Women's Health, Council on Accreditation
 National League for Nursing Accrediting Commission (NLNAC)
 Other: _____

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

Date _____



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



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CNM Practice Verification – Form 4

All applicants for licensure are required to practice a minimum of 1,040 hours as a *licensed* CNM to practice without a collaborative agreement. *If you cannot verify 1,040 hours of licensed practice*, submit a completed [Collaborative Agreement](#) with a SD licensed physician or SD licensed CNM.

Return this completed form via fax, email (Jill.Vanderbush@state.sd.us) or mail to the SD Board of Nursing.

Name: First _____ Middle _____ Last _____

License Number: _____ Social Security #: _____

Telephone: () _____ Email: _____

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

Date

This section to be completed by Employer / Agency Representative:

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the above-named individual has practiced in the role of a **licensed** CNM:

From _____
Month/Date/Year

To _____
Month/Date/Year

Total number of hours: _____

I, the undersigned, declare and affirm the information provided above for purpose of licensure is true and correct.

Signature of Agency Representative/Title

Date

Name of Employer: _____

Address of Employer: _____

Telephone: _____



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Certified Nurse Midwife Temporary Permit Application – Form 5

Please Print

1. Name: First _____ Middle _____ Last _____

2. Check type of temporary permit you are requesting:

I request a **temporary permit by examination.**

I have applied to sit for the AMCB's exam and am awaiting the results of my first exam that I am eligible to take after completing my nurse midwife education.

Requirements:

- Meet all requirements listed in the General Instructions, pages 2 - 3;
- Submit a signed Supervisory Agreement with a SD licensed physician or CNM;
- Submit a signed Collaborative Agreement with a SD licensed physician or CNM to allow you to continue to practice after your permanent license is issued;

The permit will be issued after all requirements are met:

- The holder of a temporary permit to practice will use the designation of **CNM-app** after his/her name.
- The permit becomes invalid after receipt of the results of the first exam for licensure is received.

I request a **temporary permit by endorsement.**

I hold a license as a CNM in another state or territory and have applied for and am awaiting licensure in SD.

Requirements:

- Meet all requirements listed in the General Instructions, page 3.
- Verify practice:
 - Submit Practice Verification [Form 4](#) with minimum of 1,040 hours of *licensed* practice as a CNM; **or**
 - Submit a signed Collaborative Agreement with a South Dakota licensed physician or CNM,

The permit will be issued after all requirements are met:

- The holder of a temporary permit to practice will use the designation of **CNM-app** after his/her name.
- The permit becomes invalid 120 days from issuance date.

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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Agreement must be approved prior to practice. Submit completed agreement to the Board of Nursing by email (PDF) to: Jill.Vanderbush@state.sd.us, or mail original document to SD Board of Nursing office.

Once the approval process is completed:

- Email notice will be sent to the CNM and collaborating physician or CNM within 5 – 7 business days.
- Other interested parties/employers may access the approval notice posted on the SD Board of Nursing's Online Verification website under the CNM's name: <https://www.sdbon.org/verify/>.

After the New CNM has practiced at least 1,040 hours of licensed CNM practice, the CNM may submit the Practice Verification Form to request this agreement be retired.

Advance Practice Registered Nurse Certified Nurse Midwife Collaborative Agreement

Between _____, hereinafter referred to as **New CNM**, and
_____, hereinafter referred to as **physician/CNM**.

Whereas, a Certified Nurse Midwife (CNM) license is required to practice in the role of a Nurse Midwife (CNM) in South Dakota (SD) as provided for under SDCL Chapter [36-9A](#), as administered by the SD Board of Nursing. **Whereas**, the scope of practice listed in SDCL 36-9A-13 may be performed by a CNM in collaboration with a licensed physician or CNM as defined in SDCL 36-9A-4 when licensed without the minimum 1,040 hours of licensed practice as a CNM.

Now, therefore, it is agreed between the Physician/CNM and the New CNM:

The New CNM Licensee may perform such services as are allowed by SDCL [36-9A-13](#) and not expressly excluded by SDCL Chapter [36-9A](#) for which educational and clinic competency has been demonstrated in a manner satisfactory to said Board.

36-9A-13. In addition to the registered nurse scope of practice, as defined in § 36-9-3, and within the certified nurse midwife role and population focus, a certified nurse midwife may perform the following advanced practice registered nursing scope:

- (1) Conduct an advanced assessment;
- (2) Order and interpret diagnostic procedures;
- (3) Manage the provision of women's health care throughout the lifespan, from adolescence through post menopause, including:
 - (a) Establishing primary and differential diagnoses;
 - (b) Managing prenatal care;
 - (c) Managing intrapartum care; and
 - (d) Managing postpartum care of the mother-baby unit;
- (4) Manage sexually transmitted infections in males;
- (5) Prescribe, order, administer, and furnish therapeutic measures as follows:
 - (a) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources;
 - (b) Prescribe, procure, administer, and furnish pharmacological agents, including over the counter, legend, and controlled drugs or substances listed on Schedule II in chapter [34-20B](#); and
 - (c) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services including home health care, physical and occupational therapy;
- (6) Complete and sign official documents such as death certificates, birth certificates, and similar documents required by law; and
- (7) Delegate and assign therapeutic measures to assistive personnel.

It is further understood and agreed by and between the parties:

- A. Collaboration will occur pursuant to SDCL 36-9A-1 (6). The New CNM and the physician/CNM will communicate pertinent information and consult together on patient care, with each party contributing their expertise to optimize the overall care delivered to the patient.
- B. Nothing in this agreement shall be construed to limit the responsibility of either party to the other in the fulfillment of this agreement.
- C. This agreement shall not take effect until it has been filed in the office of the SD Board of Nursing and approved by the Board and shall remain in effect until the agreement is terminated in writing by the physician/CNM or New CNM.



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- D. The agreement shall remain in effect as long as the terms defined herein describe the New CNM's current practice unless terminated in writing by either party. Upon termination of this agreement, the New CNM may not perform the services defined in SDCL [36-9A-13](#) unless a new collaborative agreement is on file with the Boards or the New CNM has met 1,040 hours of licensed CNM practice.
- E. 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 provision(s) of this agreement.

The parties hereto enter in this agreement:

Start Date:	_____ / _____ / _____.	End Date (if applicable) :	_____ / _____ / _____.
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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, such an act may constitute cause for denial of approval and discipline of my license to practice in South Dakota.

Please Print

New CNM Licensee Name:		Date:
Email Address:		License #:
Signature:		

Collaborating Physician / CNM Name:		Date:
Email Address:		License #:
Signature:		



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Advance Practice Registered Nurse Nurse Midwife Supervisory Agreement for Temporary Permit to Practice

Whereas, a Certified Nurse Midwife (CNM) license or temporary permit is required to practice in the role of a CNM in South Dakota (SD) as provided for under SDCL Chapter [36-9A](#), as administered by the SD Board of Nursing, hereinafter referred to as Board. **And Whereas**, the scope of practice listed in SDCL 36-9A-13 may be performed by the CNM applicant, herein referred to as CNM-App, under the supervision of a licensed physician or CNM as defined in SDCL 36-9A, while holding a temporary CNM permit.

Now, therefore, it is agreed between the Physician/CNM and the CNM-App:

The CNM-App may perform such services as are allowed by SDCL [36-9A-13](#) and not expressly excluded by SDCL Chapter [36-9A](#) for which educational and clinical competency has been demonstrated in a manner satisfactory to said Board.

36-9A-13. In addition to the registered nurse scope of practice, as defined in § 36-9-3, and within the certified nurse midwife role and population focus, a certified nurse midwife may perform the following advanced practice registered nursing scope:

- (1) Conduct an advanced assessment;
- (2) Order and interpret diagnostic procedures;
- (3) Manage the provision of women's health care throughout the lifespan, from adolescence through post menopause, including:
 - (a) Establishing primary and differential diagnoses;
 - (b) Managing prenatal care;
 - (c) Managing intrapartum care; and
 - (d) Managing postpartum care of the mother-baby unit;
- (4) Manage sexually transmitted infections in males;
- (5) Prescribe, order, administer, and furnish therapeutic measures as follows:
 - (a) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources;
 - (b) Prescribe, procure, administer, and furnish pharmacological agents, including over the counter, legend, and controlled drugs or substances listed on Schedule II in chapter [34-20B](#); and
 - (c) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services including home health care, physical and occupational therapy;
- (6) Complete and sign official documents such as death certificates, birth certificates, and similar documents required by law; and
- (7) Delegate and assign therapeutic measures to assistive personnel.

It is further understood and agreed by and between the parties:

1. The CNM-App and Physician/CNM shall be subject to **thirty days of on-site, direct supervision** by the Physician/CNM. Thereafter the direct supervision shall include two, one-half business days per week of on-site supervision by a supervising physician/CNM.
2. Nothing in this agreement shall be construed to limit the responsibility of either party to the other in the fulfillment of this agreement.
3. In the event the Board puts a restriction upon the services that may be performed by the CNM-App, as a condition precedent to licensure, the Physician/CNM hereby waives any objection to the CNM-App's failure to perform tasks not permitted by said Board.
4. This agreement shall not take effect until it has been filed in the SD Board of Nursing office and approved by the Board and shall remain in effect until the temporary permit becomes invalid or unless terminated in writing by the physician/CNM or CNM-App.

Name of Practice Setting:	Address:	Phone Number:
1.		
2.		



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The parties hereto enter in this agreement on: _____ / _____ / _____

Please Print

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, such an act may constitute cause for denial of approval and discipline of my license to practice in SD.

CNM-App Name:		Date:
Email Address:		License #:
Signature:		

Supervising Physician / CNM Name:		Date:
Email Address:		License #:
Signature:		