



# 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](http://www.nursing.sd.gov)

## Certified Nurse Practitioner

### 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 SD RN license or temporary permit.
  - If not, complete [RN Application for L11/08/2016 licensure by Endorsement](#); [www.doh.sd.gov/boards/nursing](http://www.doh.sd.gov/boards/nursing)
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](http://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 [Erin.Matthies@state.sd.us](mailto:Erin.Matthies@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.
4. Contact your local law enforcement agency for fingerprinting.
5. Send to the SD Board of Nursing office your completed fingerprint cards and 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.

### 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 practitioner 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 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.) Or,
2. Complete the college's online transcript request process, have the transcript electronically sent directly to: [Erin.Matthies@state.sd.us](mailto:Erin.Matthies@state.sd.us)

### 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 to the Board office.

*Continues*

## Certification Verification

Primary source verification of successfully passing a nurse practitioner certification examination offered by the American Academy of Nurse Practitioners – Certification Program (AANP-CP), American Nurses Credentialing Center (ANCC), National Certification Corporation (NCC), or the Pediatric Nursing Certification Board (PNCB) and maintaining current certification is required for licensure and renewal in SD. Refer to the certification organizations websites to request primary source verification of your certification status be sent directly to the Board office.

## Advance Practice Nursing Functions

Licensure as a nurse practitioner permits the licensee to practice advance practice nursing functions as defined in SDCL [36-9A-13.1](#) which reads as follows:

The nurse practitioner advanced practice nursing functions include:

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

## Collaborative Agreement – Required to Practice Overlapping Medical Scope and Functions

The CNP 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 SD. 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-12](#) must be submitted for Board review and approval prior to implementing the modifications.

With an approved collaborative agreement, according to SDCL [36-9A-12](#), the nurse practitioner may perform the following overlapping scope of advanced practice nursing and medical functions including:

1. The initial medical diagnosis and the institution of a plan of therapy or referral;
2. The prescription of medications and provision of drug samples or a limited supply of labeled medications, including controlled drugs or substances listed on Schedule II in Chapter [34-20B](#) for one period of not more than thirty days, for treatment of causative factors and symptoms. 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;
3. The writing of a chemical or physical restraint order when the patient may do personal harm or harm others;
4. The completion and signing of official documents such as death certificates, birth certificates, similar documents required by law; and
5. The performance of a physical examination for participation in athletics and the certification that the patient is healthy and able to participate in athletics.

## Temporary Permit

To practice as a nurse practitioner in SD, 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 **CNP-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 4](#) with \$25 fee.
  - c. Verification of current RN licensure.
  - d. Verification of education – Completed [Form 3](#) or Transcript verifying degree was conferred;
  - e. Verification of examination eligibility: Documentation from AANP-CP, ANCC, NCC, or PNCB 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.
  - f. [Supervisory Agreement](#) with a physician licensed in SD, allows you 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 SD Board of Nursing office.
  - g. Fingerprint cards (see [Criminal Background Check](#) above)

**Continues**

2. A **temporary permit by endorsement** is issued to an applicant who holds licensure as a NP 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 4](#) with \$25 fee.
  - c. Verification of current RN licensure.
  - d. Verification of current NP licensure.
  - e. Verification of current certification in role of NP. Provide a copy of your current certification card from AANP-CP, ANCC, NCC, or PNCB – OR – have primary source verification of current certification sent directly from the certification organization.
  - f. Submit [Collaborative Agreement](#) for Joint Board review and approval to perform overlapping scope of advanced practice nursing and medical functions.
  - g. Fingerprint cards (see [Criminal Background Check](#) above)



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## Certified Nurse Practitioner 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 CNP 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 Nurse Practitioner nursing education:

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

4. Indicate current NP national certification(s) that you hold or will be obtaining:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Acute Care                     | <input type="checkbox"/> Family Across the Lifespan              | <input type="checkbox"/> Pediatric Acute Care   |
| <input type="checkbox"/> Adult                          | <input type="checkbox"/> Gerontology                             | <input type="checkbox"/> Pediatric Primary Care |
| <input type="checkbox"/> Adult-Gerontology Acute Care   | <input type="checkbox"/> Neonatal                                | <input type="checkbox"/> Women's Health         |
| <input type="checkbox"/> Adult-Gerontology Primary Care | <input type="checkbox"/> Psych-Mental Health Across the Lifespan |   |

5. Information regarding your national NP certification(s):

Certification Body	Pending certification (as applicable)	Certification #	Date Issued	Expiration Date
	Exam date:			
	Exam date:			

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

6. 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: \_\_\_\_\_

7. 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.

8. Disciplinary Information:

1.	Have you ever 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?  <b>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.</b>	<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 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 sum of \$1,000 or more?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>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.</b>			

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 Practitioner 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: [Erin.Matthies@state.sd.us](mailto:Erin.Matthies@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 Practitioner Education Verification – Form 3

**Applicant, complete the top section then forward to the Director of the nursing program (not 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 School: \_\_\_\_\_

Location of School: (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 NP license in the \_\_\_\_\_ focus area (see focus areas listed below). Please complete this form and forward to the South Dakota Board of Nursing office.

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: [Erin.Matthies@state.sd.us](mailto:Erin.Matthies@state.sd.us)

1. Type of NP Program (check one):

Certificate     Master's Degree     Post-Graduate Certificate     DNP     Other \_\_\_\_\_

2. The applicant was educated as an NP in the following focus area(s):

<input type="checkbox"/> Acute Care	<input type="checkbox"/> Family Across the Lifespan	<input type="checkbox"/> Pediatric Acute Care
<input type="checkbox"/> Adult	<input type="checkbox"/> Gerontology	<input type="checkbox"/> Pediatric Primary Care
<input type="checkbox"/> Adult-Gerontology Acute Care	<input type="checkbox"/> Neonatal	<input type="checkbox"/> Women's Health
<input type="checkbox"/> Adult-Gerontology Primary Care	<input type="checkbox"/> Psych-Mental Health Across the Lifespan	

3. At the time the Applicant graduated, the program was accredited by:

Accreditation Commission for Education in Nursing (ACEN)  
 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 national nursing accreditation agency: \_\_\_\_\_

\_\_\_\_\_  
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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## Certified Nurse Practitioner Temporary Permit Application – Form 4

**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 an approved national certification exam and am awaiting the results of my first exam that I am eligible to take after completing my nurse practitioner education.

- Submission of a signed Supervisory Agreement with a SD licensed physician is required.
- Submission of a signed Collaborative Agreement with a SD licensed physician is required to allow you to continue to practice overlapping scope of advance practice nursing and medical functions after your permanent license is issued, pursuant to SDCL 36-9A-12.
- A temporary permit will be issued upon meeting all requirements listed in the General Instructions, page 3.
- The holder of a temporary permit to practice will use the designation of **CNP-app** after his/her name.

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

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

- Submission of a signed Collaborative Agreement with a South Dakota licensed physician is required to allow you to practice overlapping scope of advance practice nursing and medical functions, pursuant to SDCL 36-9A-12.
- A temporary permit will be issued upon meeting all requirements listed in the General Instructions, page 3.
- The permit becomes invalid 120 days from issuance date.
- The holder of a temporary permit to practice will use the designation of **CNP-app** after his/her name.

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 South Dakota Board of Nursing by email (PDF) to: [Erin.Matthies@state.sd.us](mailto:Erin.Matthies@state.sd.us), or send original document by mail to South Dakota Board of Nursing; 4305 S. Louise Avenue, Suite 201; Sioux Falls, South Dakota 57106-3115.

Once the approval process is completed:

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

## Advance Practice Registered Nurse Certified Nurse Practitioner Collaborative Agreement

Between \_\_\_\_\_, hereinafter referred to as **Nurse Practitioner**, and  
\_\_\_\_\_, hereinafter referred to as **physician**.

**Whereas**, a Certified Nurse Practitioner (CNP) license is required to practice in the role of a Nurse Practitioner (NP) in South Dakota (SD) as provided for under SDCL Chapter [36-9A](#), as administered by the SD Board of Nursing and the SD Board of Medical and Osteopathic Examiners, hereinafter referred to as Boards. **Whereas**, the overlapping scope of advanced practice nursing and medical functions listed in SDCL 36-9A-12 may be performed by the licensed NP in collaboration with a licensed physician as defined in SDCL 36-9A-17 and ARSD 20:62:03.

**Whereas**, the Boards recognize nationally acknowledged competencies to describe standards of practice for the NP role within six population-focused areas: *adult-gero primary care, adult-gero acute care, family across the lifespan, neonatal, pediatric acute care, pediatric primary care, psychiatric-mental health across the lifespan, or women's health / gender specific*; and **whereas**, the NP holds national certification and is licensed in at least one population-focused area to manage health care for patients in that focus area(s). (Competency documents available on National Organization of Nurse Practitioner Faculties website: <http://www.nonpf.org/>)

### Now, therefore, it is agreed between the physician and the NP:

- A. The NP may perform such services as are allowed by SDCL [36-9A-12](#) 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-15](#) and [36-9A-12](#).
1. The initial medical diagnosis and the institution of a plan of therapy or referral;
  2. The prescription of medications and provision of drug samples or a limited supply of labeled medications, including controlled drugs or substances listed on Schedule II in chapter 34-20B for one period of not more than thirty days, for treatment of causative factors and symptoms. 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;
  3. The writing of a chemical or physical restraint order when the patient may do personal harm or harm others;
  4. The completion and signing of official documents such as death certificates, birth certificates, and similar documents required by law; and
  5. The performance of a physical examination for participation in athletics and the certification that the patient is healthy and able to participate in athletics.
- B. The NP may request to perform additional tasks based upon a finding of adequate collaboration, training, and proficiency, pursuant to SDCL 36-9A-17.1.

Request additional task. (Describe and attach additional documentation) \_\_\_\_\_

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

1. **Collaboration by *direct personal contact* will occur** (ARSD [20:62:03:03](#)).

*Collaboration means communicating pertinent information or consulting with a physician, licensed pursuant to Chapter [36-4](#), with each provider contributing their respective expertise to optimize the overall care delivered to the patient. (SDCL [36-9A-1\(7\)](#)*

*Direct personal contact means that both the collaborating physician and the nurse practitioner are physically present or available by means of electronic communication for the purposes of collaboration. (ARSD [20:62:03:04](#))*

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 Boards put a restriction upon the services performed by the NP, the Physician hereby waives any objection to the NP's failure to perform tasks not permitted by said Boards.
4. The Boards will not approve any agreement that includes abortion as a permitted procedure (SDCL [36-9A-17.2](#))

D. A physician may establish a collaborative relationship with up to four full-time equivalents (FTE), (SDCL [36-9A-17.1](#)).

**Indicate the FTE status requested:**

\_\_\_\_\_ **Full-time:** 100% FTE status      **or**      \_\_\_\_\_ **% Part-time:** FTE status (e.g.: 10%, 20%, 30%, etc.)

E. **This agreement shall not take effect until it has been filed in the office of the State Board of Nursing and approved by the Boards and shall remain in effect until the agreement is terminated in writing by the physician or nurse practitioner.**

**The agreement shall remain in effect as long as the terms defined herein describe the CNP's current practice unless terminated in writing by either party.** Upon termination of this agreement, the CNP 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 CNP 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 provision(s) of this agreement.

F. The parties hereto enter in this agreement:

Start Date:	_____ \ \ _____	End Date (if applicable):	_____ \ \ _____
-------------	-----------------	---------------------------	-----------------

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**

CNP Name:		DATE: _____ \ \ _____
Email Address:		License #:
<b>Signature:</b>		

Primary Collaborating Physician Name:		DATE: _____ \ \ _____
Email Address:		License #:
<b>Signature:</b>		





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## Advance Practice Registered Nurse Nurse Practitioner Supervisory Agreement for Temporary Permit to Practice

**Whereas**, a Certified Nurse Practitioner (CNP) license or temporary permit is required to practice in the role of a Nurse Practitioner (NP) in South Dakota (SD) as provided for under SDCL Chapter [36-9A](#), as administered by the SD Board of Nursing and the SD Board of Medical and Osteopathic Examiners, hereinafter referred to as Boards.

**And Whereas**, the overlapping scope of advanced practice nursing and medical functions listed in SDCL 36-9A-13 may be performed by the licensed NP in collaboration with a licensed physician as defined in SDCL 36-9A-17 and ARSD 20:62:03; or under the supervision of a physician while holding a temporary permit, as defined in SDCL 36-9A-2.1 and ARSD 20:62:02:03.

**Now, therefore, it is agreed between the physician and the nurse practitioner:**

- A. The NP may perform such services as are allowed by SDCL [36-9A-12](#) 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.
  - 1. The initial medical diagnosis and the institution of a plan of therapy or referral;
  - 2. The prescription of medications and provision of drug samples or a limited supply of labeled medications, including controlled drugs or substances listed on Schedule II in chapter 34-20B for one period of not more than thirty days, for treatment of causative factors and symptoms. 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;
  - 3. The writing of a chemical or physical restraint order when the patient may do personal harm or harm others;
  - 4. The completion and signing of official documents such as death certificates, birth certificates, and similar documents required by law; and
  - 5. The performance of a physical examination for participation in athletics and the certification that the patient is healthy and able to participate in athletics.
  
- B. It is further understood and agreed by and between the parties:
  - 1. **The Nurse Practitioner 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 NP; 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 NP, as a condition precedent to licensure, the Physician hereby waives any objection to the NP 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. **List South Dakota practice setting(s) of the NP:** *(Attach additional page as needed)*

Name of Practice Setting:	Address:	Phone Number:
1.		
2.		
3.		
4.		

D. A physician may establish a collaborative relationship with up to four full-time equivalents (FTE), pursuant to SDCL [36-9A-17.1](#).

List the FTE status requested for the NP:

Full-time: 100% FTE status      OR      Part-time: \_\_\_\_\_ % FTE status (e.g.: 10%, 20%, 30%, etc.)

E. This agreement shall not take effect until it has been filed in the SD Board of Nursing office and approved by the Boards and shall remain in effect until the temporary permit becomes invalid or unless terminated in writing by the physician or NP.

F. The parties hereto enter in this agreement on:

Start Date:	_____ \ _____,	End Date (if applicable) :	_____ \ _____.
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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.

CNP NAME: <i>(Print)</i>	
Signature:	
Email Address:	

SUPERVISING PHYSICIAN NAME: <i>(Print)</i>		SD LICENSE #:
Signature:		
Email Address:		

**Secondary Physician(s):**

If the primary physician is unavailable, or unable to meet the standard of supervision, the physician or physicians identified in this agreement as secondary physicians, have agreed to provide the required supervision.

SECONDARY PHYSICIAN NAME: <i>(Print)</i>	SD LICENSE #:	DATE:	SIGNATURE: