



South Dakota Board of Nursing
 Unlicensed Assistive Personnel
 4305 South Louise Avenue Suite 201
 Sioux Falls SD 57106-3115
 (605) 362-2760 Fax: (605) 362-2768

CERTIFIED NURSE AIDE (CNA) REGISTRY RENEWAL APPLICATION

Allow up to 5-7 business days for the SDBON to process your application

To renew registration, the Nurse Aide shall submit verification of:

- a minimum of 12 hours of training **per year** as required in § 44:74:02:02(4), and
 - a minimum of 12 hours of employment as a nurse aide for monetary compensation during the preceding 24 months.
- Contact diana.weiland@state.sd.us for questions on in-service training requirements.

An incomplete form will result in denial of registration renewal.

THIS SECTION TO BE COMPLETED BY NURSE AIDE APPLICANT

NAME (FIRST/MIDDLE/LAST): _____

OTHER NAMES USED (MAIDEN, FORMER): _____

CERTIFICATE #A0 _____

SS# _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY, ST, ZIP: _____

HOME PHONE: _____

EMAIL: _____

CELL PHONE: _____

Native American Asian/Pacific Islander Black Hispanic White Other

DISCIPLINARY INFORMATION:

Please provide details and/or documentation to explain each question with a “yes” answer. You may attach additional pages to the application if needed. If further information is required, you will be notified by the Board.

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 that have not previously been reported to the Department of Health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Is there any pending criminal prosecution against you which would constitute a felony?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you ever had an allegation against you for abuse, neglect, or misappropriation of property?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Are you currently being investigated or is disciplinary action pending against any license(s) or certificate(s) held by you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Has any 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
6.	Have you ever had privileges revoked, reduced, or otherwise restricted at any healthcare provider entity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	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
8.	Do you currently owe child support arrearages in the amount of \$1000 or more?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance since your last renewal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	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
11.	Have you ever had action taken against you by the Office of Inspector General (OIG)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



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THIS SECTION TO BE COMPLETED BY NURSE AIDE APPLICANT

- YES NO I have been employed for monetary compensation as a nurse aide during the preceding 24 months for at least 12 hours.
- YES NO I have completed a minimum of 12 hours of training **per year** (24 hours total) within the last 24 months.
- YES NO Do you have a record of abuse, neglect, misappropriation, or is there any pending action?

*I declare and affirm that, to the best of my knowledge and belief,
all of the information provided on this application is complete, true, and correct.*

CNA SIGNATURE: _____ DATE: _____

VERIFICATION – THIS SECTION TO BE COMPLETED BY EMPLOYER

DATES OF EMPLOYMENT: FROM _____ TO _____ (If presently employed, use “present”)

Total number of hours worked during this period: _____

- YES NO This applicant has completed a minimum of 12 hours of training per year within the last 24 months (24 hours total)
- YES NO Does this applicant have a record of abuse, neglect, or misappropriation, or is there any pending action?
- YES NO I affirm that, to the best of my knowledge, all information provided on this Verification is complete, true, and correct.

An incomplete form will result in denial of registration renewal.

EMPLOYER: _____

ADDRESS: _____

CITY, ST, ZIP: _____

TELEPHONE: _____ DATE: _____

EMPLOYER REPRESENTATIVE SIGNATURE / TITLE: _____