



South Dakota Board of Nursing
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

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 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 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 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

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.

Continues

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.

Advance Practice Nursing Functions

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

The nurse midwife advanced practice nursing functions include:

1. Providing advanced nursing assessment, nursing intervention, and nursing case management;
2. Providing advanced health promotion and maintenance education and counseling to clients, families, and other members of the health care team;
3. Utilizing research findings to evaluate and implement changes in nursing practice, programs and policies; and
4. 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 CNM 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. The CNM may request to modify functions described in SDCL 36-9A-13 (see below) and must submit the request for Board review and approval prior to implementing the modifications.

With an approved collaborative agreement, according to SDCL [36-9A-13](#), the nurse midwife may perform the following overlapping scope of advanced practice nursing and medical functions including:

1. Management of the prenatal and postpartum care of the mother-baby unit;
2. Management and direction of the birth;
3. Provision of appropriate health supervision during all phases of the reproductive life span to include family planning services, menopausal care, and cancer screening and prevention; and
4. Prescription of appropriate medications and provision of drug samples or a limited supply of appropriate labeled medications for individuals under the nurse midwife's care pursuant to the scope of practice defined in this section, including controlled drugs or substances listed on Schedule II in Chapter [34-20B](#) for one period of not more than thirty days. 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.

Temporary Permit

To practice as a nurse midwife 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 **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 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 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.
 - 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 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 4](#) with \$25 fee.
 - c. Verification of current RN licensure.
 - d. Verification of current CNM licensure.
 - e. Verification of current certification by AMCB. Provide a copy of your current certification card – OR – have primary source verification of current certification sent directly from AMCB to the Board office.
 - 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](#))



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, answer question 2. No

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.

Continues

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. 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? 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 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.	Within the last two years, have you been treated for abuse or misuse of any alcohol or chemical substance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8.	Within the last two years, have you 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

For 2-9 above, provide 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



South Dakota Board of Nursing
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ www.state.sd.us/doh/nursing

Certified Nurse Midwife
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

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: Erin.Matthies@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.



Certified Nurse Midwife
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 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.

- 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-13.
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 CNM-app after his/her name.

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.

- 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-13.
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 CNM-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



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

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, or send original document by mail to SD 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 SD Board of Nursing's Online Verification website under the APRN's name: <https://www.sdbon.org/verify/>.

Advance Practice Registered Nurse Certified Nurse Midwife Collaborative Agreement

Between _____, hereinafter referred to as **Certified Nurse Midwife**,
and _____, hereinafter referred to as **physician**.

Whereas, a Certified Nurse Midwife (CNM) license is required to practice in the role of a Nurse Midwife 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-13 may be performed by the licensed CNM in collaboration with a licensed physician as defined in SDCL 36-9A-17 and ARSD 20:62:03.

And Whereas, the Boards recognize the following nationally recognized documents to describe standards of practice and entry-level competencies for the practice of the CNM, *American College of Nurse-Midwives: Core Competencies for Basic Midwifery Practice* (December 2012) and *Standards for the Practice of Midwifery* (September 2011). <http://www.midwife.org/index.asp?bid=59&cat=2&button=Search>

Now, therefore, it is agreed between the physician and the CNM:

A. The CNM may perform such services as are allowed by SDCL [36-9A-13](#) and other tasks authorized by the Boards and not expressly excluded by SDCL Chapter [36-9A](#) for which educational and clinical competency has been demonstrated in a manner satisfactory to said Boards, pursuant to SDCL [36-9A-15](#) and [36-9A-13](#).

1. Management of the prenatal and postpartum care of the mother-baby unit;
2. Management and direction of the birth;
3. Provision of appropriate health supervision during all phases of the reproductive life span to include family planning services, menopausal care, and cancer screening and prevention; and
4. Prescription of appropriate medications and provision of drug samples or a limited supply of appropriate labeled medications for individuals under the nurse midwife's care pursuant to the scope of practice defined in this section, including controlled drugs or substances listed on Schedule II in chapter 34-20B for one period of not more than thirty days. 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.

B. The CNM 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 no less than twice each month**, unless a modification request is approved by the Joint Boards that one of the twice monthly meetings be held by telecommunication (ARSD [20:62:03:03](#)). Direct personal contact means the physician and NP are physically present on site and available for the purposes of collaboration (ARSD [20:62:03:04](#)).

The CNM and physician request one of the twice monthly meetings be held by telecommunication.

The term *collaboration* (SDCL [36-9A-1\(7\)](#)) is defined as the act of communicating pertinent information or consulting with physician(s) licensed pursuant to Chapter [36-4](#), with each provider contributing their respective expertise to optimize the overall care delivered to the patient.

2. **Collaboration - Separate practice location:** In addition to the required two meetings per month the collaborating physician or secondary physician will be physically present on-site every ninety days at each South Dakota CNM practice location (ARSD 20:62:03:05). This requirement does not apply to locations where health care services are not routine to the setting, such as patient homes and school health screening events.
3. When the collaborating physician is not in direct personal contact with the CNM, the physician must be available by telecommunication (ARSD [20:62:03:04](#)).
4. Nothing in this agreement shall be construed to limit the responsibility of either party to the other in the fulfillment of this agreement.
5. In the event the Boards put a restriction upon the services performed by the CNM, the Physician hereby waives any objection to the CNM's failure to perform tasks not permitted by said Boards.
6. The Boards will not approve any agreement that includes abortion as a permitted procedure, pursuant to 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). Provide the FTE status requested:
_____ Full-time: <u>100%</u> 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 midwife.**

The agreement shall remain in effect as long as the terms defined herein describe the CNM's current practice unless terminated in writing by either party. Upon termination of this agreement, the CNM 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 CNM 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 on:

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

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

Primary Collaborating Physician 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 Nurse Midwife 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 CNM 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 CNM:

- A. The CNM may perform such services as are allowed by SDCL [36-9A-13](#) 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. Management of the prenatal and postpartum care of the mother-baby unit;
 - 2. Management and direction of the birth;
 - 3. Provision of appropriate health supervision during all phases of the reproductive life span to include family planning services, menopausal care, and cancer screening and prevention; and
 - 4. Prescription of appropriate medications and provision of drug samples or a limited supply of appropriate labeled medications for individuals under the nurse midwife's care pursuant to the scope of practice defined in this section, including controlled drugs or substances listed on Schedule II in chapter 34-20B for one period of not more than thirty days. 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.

- B. It is further understood and agreed by and between the physician and the CNM:
 - 1. **The CNM 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 CNM; the secondary physician(s) identified in this agreement have agreed to provide 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 performed by the CNM, the physician hereby waives any objection to the CNM's failure to perform tasks not permitted by said Boards.
 - 5. The Boards will not approve any agreement that includes abortion as a permitted procedure, pursuant to SDCL [36-9A-17.2](#).

- C. **List** the South Dakota practice setting(s) of the CNM: *(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) (SDCL [36-9A-17.1](#)).

List the FTE status requested for the CNM:

Full-time: 100% FTE status OR Part-time: _____ % FTE status (i.e.: 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 CNM.

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.

CNM 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: