South Dakota Board of Nursing
South Dakota Department of Health
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: (605) 362-2768

CNM and CNP Practice Verification Form

To practice full scope, as defined in SDCL 36-9A-12 and 36-9A-13, as a licensed CNM or CNP in South Dakota *without* a collaborative agreement with another licensed physician, nurse practitioner or nurse midwife, you must complete and submit this form to verify that you have practiced as a *licensed* CNM or CNP a minimum of 1,040 practice hours.

Upon review an email notice will be sent within 5-7 business days to the CNM or CNP; the notice will verify practice authority status. Other interested parties/employers may verify a CNM's or CNP's practice authority status at https://www.sdbon.org/verify.

Return this completed form via fax, email (Erin.Matthies@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 / agency representative 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 or CNP:

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: ____