



South Dakota Board of Nursing Facility Administrators

P.O. Box 340, 1351 N. Harrison Ave. Pierre, SD 57501-0340

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<http://nursingfacility.sd.gov>

APPLICATION FOR INITIAL LICENSURE

Please submit the following:

1. Completed application;
2. Nonrefundable application fee of \$300;
3. State examination fee of \$100 (*Exam information will be emailed to you upon receipt of application and fees.*);
4. A copy of your driver license or equivalent birth verification;
5. If applicable, verification of any name change;
6. A certified copy of your transcripts verifying completion of at least an associate degree (*Transcripts must be sent to our office directly from your educational institution*);
7. A certified copy of your passing score on the Core and NHA Components of the Nursing Home Administrators Licensing Examination administered by the National Association of Long Term Care Administrator Boards (NAB) (*This must be sent directly from NAB to our office and the applicant must have passed the NAB exam within four years of the date of application.*)
8. If applicable, a verification letter from each state in which you have been licensed (*This letter must be sent directly from your state board to our office*);
9. Criminal background check (enclosed or sent separately). Criminal background check instructions: To request fingerprint materials, please call the Board office or send your request via email. Completed fingerprint cards must be submitted with a \$43.25 money order made payable to the South Dakota Division of Criminal Investigation.

If you are an active duty member of the armed forces of the United States or the spouse of an active duty member of the armed forces of the United States who is the subject to a military transfer to South Dakota and hold a license or registration in good standing to practice as a Nursing Facility Administrator in another state, please contact our office for an Active Duty Military Personnel or Spouse License or Registration Application.

Name (First, Middle and Last): _____ E-mail: _____

Address: _____ SSN: _____ DOB: _____

City: _____ State: _____ Zip: _____ Phone: _____

Nursing Facility Name: _____ Phone: _____

Physical Address: _____ Mailing address: _____

City: _____ State: _____ Zip: _____

Education:

Name of Educational Institution: _____

City _____ State _____ Zip _____

Dates attended: From _____ to _____ Date Graduated: _____

Degree: _____

Please answer the following questions:

1. Are you an active duty member or the spouse of an active duty member of the armed forces of the United States?
 Yes No
 - a. If yes, were you or your spouse the subject of a military transfer to South Dakota? Yes No
2. Do you currently hold a valid license issued by a different state or the District of Columbia to practice as a Nursing Facility Administrator? Yes No

If applicable, please submit the following information for each state in which you have been licensed. *You must also submit a certified letter verifying the license number and status of your license from the board of nursing facility administrators in each state in which you have been licensed. **These letters must be sent directly to our office.***

STATE _____ LICENSE # _____ DATE RECEIVED _____ STATUS _____
 STATE _____ LICENSE # _____ DATE RECEIVED _____ STATUS _____

3. Do you practice as a Nursing Facility Administrator:
 Full-Time Part-Time Temporary Retired/Not Working

Please select one of the following: Please attach the appropriate verification to this application.

I have completed a practicum in long-term healthcare administration from a higher education institution accredited by an organization recognized by the Council for Higher Education Accreditation within the four years preceding the date of application. Verification of completion of this practicum is attached to this application (verification must be provided by your college or university); OR

I have completed an Administrator-In-Training (AIT) program with a minimum of 240 hours within six consecutive months. This AIT program was completed within the four years preceding the date of application. Verification of this AIT program, including date of completion and number of hours of the AIT program is attached to this application (verification must be provided by your employer, preceptor or state board); OR

I intend to complete an Administrator-In-Training (AIT) program with a minimum of 240 hours within six consecutive months. *I have completed and enclosed the Preceptor and Administrator In Training (AIT) Agreement, found on the Board's website, which has been signed by my preceptor and by me.*

<u>CRIMINAL HISTORY</u>	(circle one)
1. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence, or had prosecution deferred with respect to a felony? If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communications (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements. You must attach all communications for a violation to the signed and dated explanation of that violation. Please put correspondence in chronological order (most recent first). If you have more than one violation, please do the same for each violation.	Yes No
2. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 misdemeanor traffic offense? *It is the Applicant's responsibility to determine whether an infraction is a class 1 or class 2 misdemeanor.	Yes No
3. Is there any pending criminal prosecution against you?	Yes No
4. Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	Yes No

5. Has any license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, or have you been placed on probation or otherwise subjected to any type of disciplinary action?	Yes	No
6. Have you ever been denied a license to practice in another state?	Yes	No
7. Have you ever appeared or been requested to appear before any licensing board concerning any violation of law or regulation of any state district, territory or province of the United States or Canada?	Yes	No
8. Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	Yes	No
9. Have you ever been subject to proceedings by a professional society to revoke, reduce or restrict membership?	Yes	No
10. Have you ever received care or treatment for abuse or misuse of alcohol or any chemical substance?	Yes	No
11. Have you ever received care or treatment for an emotional or mental condition or illness?	Yes	No
12. Do you currently owe child support arrearages in the amount of \$1,000 or more?	Yes	No
13. Were you subject to any ethical violations while enrolled in school?	Yes	No
14. Have you ever been released from the military by any means other than an honorable discharge?	Yes	No
15. Are you in any way using fraud or deception in applying for a license to practice in South Dakota?	Yes	No
For 2-15 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and events. You must also send ALL supporting applicable documents. You must attach supporting documents to the signed and dated explanation. Please put supporting documents in chronological order (most recent first).		

National Examination: The national examination for licensure for a Nursing Facility Administrator is administered by the National Association of Boards of Examiners of Long Term Care Administrators (NAB). You will need to apply to take the exam online at www.nabweb.org. Applicants for a new license must complete both the Core and NHA components of the exam. The Prometric testing centers are located in Sioux Falls and Rapid City. After you apply and before taking the test, you can access the website for “Information for Candidates Nursing Home Administrator Handbook” as well as practice exams. All fees will be paid directly to NAB at the time of application. *An applicant who has failed the national examination is entitled to reexamination a maximum of three times upon payment of the applicable fees. If unsuccessful after four attempts, the applicant may petition the board for reconsideration.*

State Examination: The South Dakota State exam is administered online and activated by the Board. When you submit this application with the required fee, the Board will activate your exam and an email containing the examination access information will be automatically sent to the email provided on this application. The examination will test over the Administrative Rules of South Dakota (ARSD) 20:44. You can find ARSD 44:04 on the SD Legislative Research Council website at <http://legis.sd.gov/Rules/DisplayRule.aspx?Rule=44:04&Type=All>. *An applicant who has failed the state examination is entitled to reexamination a maximum of three times upon payment of the applicable fees. If unsuccessful after four attempts, the applicant may petition the board for reconsideration.*

I declare and affirm under the penalties of perjury that this application 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 any misstatements of material facts may cause rejection of my application. I have no objection to inquiries being made for the purpose of verifying the statements made herein.

Signature of Applicant

Date

Sworn to before me this _____ day of _____, 20_____.

Notary Public Signature

My Commission Expires:

(SEAL)

For Office Use Only: Check # _____ Amount _____ Date _____

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Preceptor and Administrator-In-Training Agreement

INSTRUCTIONS: Please submit to the Board office an application for licensure with the required fee and a completed and signed Preceptor and AIT Agreement before beginning your AIT training.

A maximum of 40 hours per week may be credited toward completion of the AIT program.

AIT Information (Please print or type)

First Name:	Middle Name: Maiden Name (if applicable):	Last Name:
Mailing Address:	City:	State / Zip Code:
E-Mail Address:		
Work Phone:	Home Phone:	Mobile Phone:
Training Facility Name: Training Facility Address:	Type of Facility: Training Facility Email Address: Training Facility Phone:	

Preceptor Information (Please print or type)

First Name:	Middle Name: Maiden Name (if applicable):	Last Name:
Mailing Address:	City:	State / Zip Code:
E-Mail Address:	License Number:	
Work Phone:	Home Phone:	Mobile Phone:
Beginning Date of AIT Program: Estimated End Date of AIT Program:	<p>1. I have completed the <i>free</i> online NAB-ACHCA Preceptor Training Course. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. If yes, do you believe this course provided relevant and useful information regarding your role as a preceptor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>The Board strongly recommends that all preceptors take the online NAB-ACHCA Preceptor Training Course, which includes four 1.25 hour modules. This course is free, available online and you are eligible for continuing education hours for completing each module. This course can be accessed at https://nab.academy.reliaslearning.com/.</p>	

As the preceptor and AIT named herein, we fully understand our responsibilities as stated in the South Dakota Board of Nursing Facility Administrators regulations. We agree to inform the Board immediately if there is a change in this agreement.

As a preceptor, I agree to guide the Administrator-In-Training through the program as outlined in the following manual (*please check one*):

- National Association of Boards of Examiners for long Term Care Administrators (NAB) Administrator-In-Training (AIT) Program Manual (*2015 version*). I agree to complete the required reports using the forms approved by the Board and found on the Board's website; or
- Good Samaritan Society Administrative Internship Program Workbook (*2013 manual*). I agree to complete the required training and reports using the Internship Program Workbook. I will submit these forms to the Board upon completion of the program.

As an AIT, I understand that if an AIT program is required for licensure, my application will not be processed until all completed forms have been received by the Board with the appropriate signatures (*typed signatures will not be accepted*).

Administrator-In-Training Signature

Date

Preceptor Signature

Date