



SOUTH DAKOTA BOARD OF NURSING

4305 S. Louise Ave., Suite 201 | Sioux Falls, SD 57106-3115
605-362-2760 | <https://doh.sd.gov/boards/nursing/>

General Instructions for Licensure by Examination Certified Nurse Practitioner

Please follow instructions carefully to avoid delays in processing your application. If any 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 that your application has been approved.

Application and Fees

Complete general application [Form 1](#) and return to South Dakota (SD) Board of Nursing (BON) office. 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

You must hold an active, unencumbered SD RN license or temporary permit; or hold a compact RN license with multi state privilege to practice. If you do not hold a SD RN license, or a compact license, you must apply for SD RN licensure. Complete the [RN Application for Licensure by Endorsement](#).

Criminal Background Check

Pursuant to [SDCL 36-9A-9.1](#) each applicant for licensure must submit a full set of fingerprints to obtain a state and federal criminal background check (CBC).

The fingerprint card packet and instructions will be mailed to the address provided on your application.

- Your application for temporary permit will **not** be issued until your completed fingerprint cards are received.
- Permanent licensure will not be issued until the results of your criminal background check are received by the Board office.

Request for Transcript

Submit a transcript from **each** college, university, or program you attended, or completed course work at, that pertains to your nurse practitioner (NP) education. The college/program that issued your degree must include the date the degree was conferred/awarded or post-graduate certificate awarded, the NP role, and the population focus area(s). Copies of transcripts are not accepted. *You may choose to:*

1. Complete the college's online transcript request process, have the transcript electronically sent directly to Jill.Vanderbush@state.sd.us
2. OR – Complete the Transcript Request [Form 2](#) and send to the college's Office of the Registrar. The Registrar must send the official transcript(s) directly to the SD BON office.

Certification Verification

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

Practice Verification

All applicants for licensure are required to practice a minimum of 1,040 hours as a *licensed* NP to practice without a collaborative agreement.

If you cannot verify 1,040 hours of licensed practice you are required to submit a [Collaborative Agreement](#) with a SD licensed physician or SD licensed CNP. The physician or CNP must have a minimum of 2 years of licensed practice experience, hold an unencumbered SD license, and practice in a comparable area to your NP education and certification. Once you have met the minimum 1,040 hours of practice you may complete the Practice Verification [Form 3](#) to request retirement of the Collaborative Agreement.

Applicants may count licensed practice hours from other jurisdictions/states. Submit the Practice Verification Form 3 to verify licensed practice hours.

Advance Practice Nursing Functions and Scope

Once licensed, an NP is permitted to practice the scope defined in [SDCL 36-9A-12](#) and shall collaborate with other health care providers and refer or transfer patients as appropriate as required in [SDCL 36-9A-13.1](#).

As outlined in SDCL 36-9A-12, upon licensure, CNPs may prescribe, procure, furnish, and administer over-the-counter, legend, and controlled substance drugs, schedules II-IV, according to federal and state registration requirements. Additionally, [ARSD 20:62:03:11](#) provides further clarification on prescribing requirements.

Temporary Permit

To practice as an NP in SD, you must possess a temporary permit, or a permanent license issued by the SD Board of Nursing authorizing your practice. A temporary permit is required *before* you can begin orientation at your place of employment. The permit is valid only for the period 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 permit to practice will use the designation of **CNP-app** after name.

1. A **temporary permit by examination** is issued to an applicant who is waiting for results of the first exam they are eligible to take after completing an NP education program.

The permit will be issued when the following is completed and received in the Board office:

- a. General Application – [Form 1](#) and \$100 fee.
- b. Temporary Permit Application – [Form 4](#) and \$25 fee.
- c. Fingerprint cards (see [Criminal Background Check](#))
- d. Verification of current RN licensure.
- e. Verification of examination eligibility: Documentation from AANP-CP, ANCC, AACN, 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 SD licensed physician or SD licensed CNP. Temporary permit applicants are required to be supervised the first 30 days by direct personal contact, which means the collaborating physician or CNP is physically present and available. Thereafter, and until the expiration of the permit, supervision must include two, one-half business days per week. Upon issuance of a permanent license the Supervisory Agreement becomes invalid and the Collaborative Agreement becomes effective.
- g. [Collaborative Agreement](#) must be submitted with either a SD licensed physician or SD licensed CNP. Once the minimum of 1,040 hours of *licensed CNP* practice hours are completed the Practice Verification [Form 3](#) may be submitted to request retirement of the agreement. Hours practiced on a temporary permit are not *licensed CNP* practice hours and cannot be included in the minimum 1,040 hours.



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Certified Nurse Practitioner General Application – Form 1

Please Print

Name: First _____ Middle _____ Last _____

Maiden Name: _____ Other Name(s): _____

Home Address: _____ City _____ State _____ Zip _____
Street/PO Box

Telephone: Home: () _____ Cell: () _____ Other: () _____

Email: _____

Date of Birth: _____ **Social Security Number:** _____

US Citizen: Yes No **Gender:** Male Female

Race/Ethnicity: American Indian/Alaskan Native Asian Black / African American Hispanic / Latino

Native Hawaiian / Other Pacific Islander Other White /Caucasian

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: _____.
- Are you employed by the federal government? Yes No

1. Information regarding your **RN** education:

Institution Name	Location (City, State)	Completion Date	Degree Received: (e.g. diploma, AD, BS)

2. Information regarding your **NP** education:

Institution Name	Location (City, State)	Completion Date	Degree Received: (e.g. MS, Post Certificate, DNP)

3. 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 | |

4. Provide information regarding your NP certification(s) from AANP-CP, ANCC, AACN, NCC, or PNCB. *

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

* Request primary source verification of your certification status be sent directly to the Board office; refer to the certification organizations websites and request verification be emailed to: Jill.Vanderbush@state.sd.us

Compliance Information:

1.	Have you 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 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 been treated for abuse or misuse of any alcohol or chemical substance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7.	Are you currently enrolled in an Alternative to Discipline Program?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8.	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 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.			

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 **OPTIONAL 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: Jill.Vanderbush@state.sd.us

Applicant: complete this form for *each* college, university, or program you completed coursework from that prepared you for your CNP role. The college that awarded/conferred your graduate nursing degree should include the date the degree was awarded/conferred.

Contact the Registrar's Office(s) 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.

Forward this form to the Office of the Registrar.

Please Print

1. Name: First _____ Middle _____ Last _____
2. Maiden and Other Names Previously used: _____
3. Address: _____ City _____ State _____ Zip _____
Street/PO Box
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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CNP Practice Verification – Form 3

All applicants for licensure are required to practice a minimum of 1,040 hours as a *licensed* CNP to practice without a collaborative agreement. *If you cannot verify 1,040 hours of licensed practice*, submit a completed [Collaborative Agreement](#) with a SD licensed physician or SD licensed CNP.

Return this completed form via fax, email (Jill.Vanderbush@state.sd.us) or mail to the SD Board of Nursing.

Name: First _____ Middle _____ Last _____

Social Security #: _____

Telephone: () _____ Email: _____

I, hereby request and authorize my employer / former employer 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** 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: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____



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Certified Nurse Practitioner Temporary Permit Application – Form 4

Please Print

Name: First _____ Middle _____ Last _____

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.

Requirements:

- Meet all requirements listed in the General Instructions, [page 2](#);
- Submit a signed [Supervisory Agreement](#) with a SD licensed physician or CNP;
- Submit a signed [Collaborative Agreement](#) with a SD licensed physician or CNP to allow you to continue to practice after your permanent license is issued;

The permit will be issued after all requirements are met:

- The holder of a temporary permit to practice will use the designation of **CNP-app** after his/her name.
- The permit becomes invalid after receipt of the results of the first exam for licensure is received.

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 Board of Nursing by email (PDF) to Jill.Vanderbush@state.sd.us or mail original document to the SD Board of Nursing office.

Once the approval process is completed:

- Other interested parties/employers may access the approval notice posted on the Board of Nursing's Online Verification website under the CNP's name: <https://www.sdbon.org/verify/>.

After the New CNP has practiced at least 1,040 hours of licensed CNP practice, the CNP may submit the [Practice Verification Form](#) to request this agreement be retired.

Advance Practice Registered Nurse Certified Nurse Practitioner Collaborative Agreement

Between _____, hereinafter referred to as **New CNP**, and
_____, hereinafter referred to as **Physician/CNP**.

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. **Whereas**, the scope of practice listed in [SDCL 36-9A-12](#) may be performed by a CNP in collaboration with a licensed physician or CNP as defined in [SDCL 36-9A-4](#) when licensed without the minimum 1,040 hours of licensed practice as a CNP.

Now, therefore, it is agreed between the Physician/CNP and the New CNP:

The New CNP Licensee may perform such services as are allowed by SDCL [36-9A-12](#) and not expressly excluded by SDCL Chapter [36-9A](#) for which educational and clinic competency has been demonstrated in a manner satisfactory to said Board.

[36-9A-12](#). In addition to the registered nurse scope of practice, as defined in § [36-9-3](#), and within the certified nurse practitioner role and population focus, a certified nurse practitioner may perform the following advanced practice registered nursing scope:

- (1) Conduct an advanced assessment;
- (2) Order and interpret diagnostic procedures;
- (3) Establish primary and differential diagnoses;
- (4) Prescribe, order, administer, and furnish therapeutic measures as follows:
 - (a) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources;
 - (b) Prescribe, procure, administer, and furnish pharmacological agents, including over the counter, legend, and controlled drugs or substances listed on Schedule II in chapter [34-20B](#);
 - (c) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including durable medical equipment, medical devices, nutrition, blood and blood products, diagnostic, and supportive services including home health care, hospice, and physical and occupational therapy; and
 - (d) Write a chemical or physical restraint order when the patient may do personal harm or harm others;
- (5) Perform a physical examination for the determination of participation in athletics or employment duties;
- (6) Complete and sign official documents such as death certificates, birth certificates, and similar documents required by law; and
- (7) Delegate and assign therapeutic measures to assistive personnel.

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

- A. Collaboration will occur pursuant to SDCL [36-9A-1](#) (6). The New CNP and the physician/CNP will communicate pertinent information and consult together on patient care, with each party contributing their expertise to optimize the overall care delivered to the patient.
- B. Nothing in this agreement shall be construed to limit the responsibility of either party to the other in the fulfillment of this agreement.
- C. This agreement shall not take effect until it has been filed in the office of the SD Board of Nursing and approved by the Board and shall remain in effect until the agreement is terminated in writing by the physician/CNP or New CNP.

- D. The agreement shall remain in effect as long as the terms defined herein describe the New CNP's current practice unless terminated in writing by either party. Upon termination of this agreement, the New CNP may not perform the services defined in SDCL [36-9A-12](#) unless a new collaborative agreement is on file with the Boards or the New CNP has met 1,040 hours of licensed CNP practice.
- E. 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.

The parties hereto enter in this agreement:

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

Name of New CNP:			
Email Address:			
Signature:			

Name of Collaborating Physician or CNP:		SD License #:
Have you practiced for a minimum of 2 years as a licensed professional?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address:		
Signature:		



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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, hereinafter referred to as Board. **And Whereas**, the scope of practice listed in SDCL [36-9A-12](#) may be performed by the CNP applicant, herein referred to as CNP-App, under the supervision of a licensed physician or CNP as defined in SDCL 36-9A, while holding a temporary CNP permit.

Now, therefore, it is agreed between the physician/CNP and the CNP-App:

The CNP-App may perform such services as are allowed by SDCL [36-9A-12](#) and not expressly excluded by SDCL Chapter [36-9A](#) for which educational and clinical competency has been demonstrated in a manner satisfactory to said Board.

[36-9A-12](#). In addition to the registered nurse scope of practice, as defined in § 36-9-3, and within the certified nurse practitioner role and population focus, a certified nurse practitioner may perform the following advanced practice registered nursing scope:

1. Conduct an advanced assessment;
2. Order and interpret diagnostic procedures;
3. Establish primary and differential diagnoses;
4. Prescribe, order, administer, and furnish therapeutic measures as follows:
 - a) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources;
 - b) Prescribe, procure, administer, and furnish pharmacological agents, including over the counter, legend, and controlled drugs or substances listed on Schedule II in chapter [34-20B](#);
 - c) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including durable medical equipment, medical devices, nutrition, blood and blood products, diagnostic, and supportive services including home health care, hospice, and physical and occupational therapy; and
5. Write a chemical or physical restraint order when the patient may do personal harm or harm others;
6. Perform a physical examination for the determination of participation in athletics or employment duties;
7. Complete and sign official documents such as death certificates, birth certificates, and similar documents required by law; and
8. Delegate and assign therapeutic measures to assistive personnel.

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

1. The CNP-App and Physician/CNP shall be subject to **thirty days of on-site, direct supervision** by the Physician/CNP. Thereafter the direct supervision shall include two, one-half business days per week of on-site supervision by a supervising physician/CNP.
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 Board puts a restriction upon the services that may be performed by the CNP-App, as a condition precedent to licensure, the Physician/CNP hereby waives any objection to the CNP-App's failure to perform tasks not permitted by said Board.
4. This agreement shall not take effect until it has been filed in the SD Board of Nursing office and approved by the Board and shall remain in effect until the temporary permit becomes invalid or unless terminated in writing by the physician/CNP or CNP-App.

NAME OF PRACTICE SETTING:	ADDRESS:	PHONE NUMBER:
1.		
2.		

The parties hereto enter in this agreement on: ____ / ____ / ____

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-App Name:		
Email Address:		
Signature:		
Supervising Physician / CNP Name:		SD LICENSE #:
Have you practiced for a minimum of 2 years as a licensed professional?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address:		
Signature:		