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South Dakota Board of Nursing
SDBON

SOUTH DAKOTA BOARD OF NURSING

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

Medication Administration Training Program
Renewal Application

For use only by programs who missed the renewal date of April 30th.

To request renewal, complete and submit this application to the Board of Nursing by mail to the address listed above or fax to 605-362-2768. **Notice of approval or denial will be emailed to the primary instructor issued within 5 – 7 business days.**

Name of Program: _____

Address: _____

Phone Number: _____

1. Identify name of primary RN instructor: _____
2. E-mail Address: _____
3. Phone number: _____
4. List all RN instructors who have a minimum of 2 years clinical RN nursing experience.

RN FACULTY/INSTRUCTOR NAME(S)	RN LICENSE INFORMATION				
	State	Number	I verified this RN has a minimum of 2 years clinical RN experience:		Verification *(Completed by SDBON)*
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	

Complete evaluation of the curriculum / program: *(Explain 'No' responses on a separate sheet of paper.)*

Standard	Yes	No
1. Each person enrolled in your program had a high school diploma or the equivalent.		
2. Your program was no less than 16 classroom hours and 4 hours clinical/laboratory instruction for a total of 20 hours.		
3. Your program's faculty to student ratio did not exceed 1:8 in the clinical / lab setting		
4. Your program's faculty to student ratio did not exceed 1:1 in skill performance evaluation /competency validation.		
5. Each student's performance was documented using the SD clinical skills checklist form.		
6. You maintain records using the Enrolled Student Log(s) form.		

Affidavit: I, the undersigned, 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 further agree, as the primary RN instructor, to teach the medication aide training program using one of the SDBON's approved curriculums, the Clinical Skills Checklist, the Enrolled Student Log form, and will issue successful students a Certificate of Completion.

Primary RN Instructor Applicant's Signature: _____ Date: _____

This section to be completed by the South Dakota Board of Nursing

Date Application Approved:	Expiration Date of Approval:	Board Representative: