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/**

Medication Administration Training Program

Initial Program Application

To request approval of a MATP, complete and submit this application to the Board of Nursing by mail to the address listed above, fax, or email to sduap@state.sd.us. **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	
			☐ Yes	☐ No	

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: