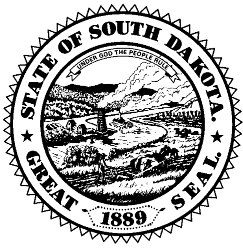

South Dakota Board of Nursing Facility Administrators
P.O. Box 340, 1351 N. Harrison Ave. Pierre, SD 57501-0340
Ph.: 605-224-1721 Fax: 888-425-3032
E-mail: SDNFA@midwestsolutionssd.com http://nursingfacility.sd.gov

APPLICATION FOR RECIPROCAL LICENSURE

The following items are required to complete your application:

- ☐ Completed application;
- ☐ Nonrefundable application fee of $390;
- ☐ State examination fee of $100;
  - The South Dakota state exam is administered online. After receipt of this application with the required fee, the Board will activate your exam and an email containing examination information will be 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.
- ☐ A copy of your driver license or equivalent birth verification;
- ☐ If applicable, verification of any name change;
- ☐ A certified copy of your transcripts verifying completion of at least an associate degree;
  - *Transcripts must be sent directly from your educational institution to our office via mail or email.*
- ☐ Verification of your passing score on the Nursing Home Administrators Licensing Examination administered by the National Association of Long Term Care Administrator Boards (NAB);
  - Individuals who completed the exam after July 2017 must submit scores for both the CORE and NHA components.
  - 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.
  - *NAB scores must be sent directly from NAB to our office via mail or email.*
- ☐ One of the following:
  - Verification of at least six consecutive months of service as an administrator within the four years preceding the date of application;
  - Verification of completion of a practicum in long-term healthcare administration within the four years preceding the date of application; or
  - Verification of completion of an AIT within the four years preceding the date of application.
- ☐ If applicable, a verification letter from each state in which you have been licensed;
  - *Verification letters must be sent directly from your state board to our office via mail or email if that state does not provide online verification.*
- ☐ Criminal background check materials (enclosed or sent separately).
  - To request fingerprint materials, please send your request via email to SDNFA@midwestsolutionssd.com. 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.

SOUTH DAKOTA BOARD OF NURSING FACILITY ADMINISTRATORS
APPLICATION FOR RECIPROCAL LICENSURE

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: ____

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

   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 yes, please submit the following information for each state in which you have been licensed. *You must also request a letter verifying the 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 via mail or email if that state does not provide online verification.*

   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 demonstrated at least six consecutive months of service as an administrator of a licensed nursing facility in the state that I am currently licensed in. This service was provided within the four years preceding the date of application. *A letter from my employer verifying this service is attached to this application*; *OR*

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. (V*erification 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).*

CRIMINAL HISTORY	
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).	

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_________.

____ My Commission Expires:
Notary Public Signature

(SEAL)

Mail completed application and fees to:

South Dakota Board of Nursing Facility Administrators
PO Box 340
Pierre, SD 57501

For Office Use Only: Check # _________________*Amount* ____________________ *Date* ________

SOUTH DAKOTA BOARD OF NURSING FACILITY ADMINISTRATORS
APPLICANT'S LETTER OF RECOMMENDATION
(Professional reference may not be related to the applicant by kinship or marriage)

FROM: ____

TITLE: ____

PLACE OF EMPLOYMENT: ______________________________ PHONE: ____________________

ADDRESS: ________________________ ________________ ________ ____________

Street/PO Box City State Zip Code

I, ______________________________, would recommend that __________________________, be given the opportunity to take the Nursing Facility Administration State and National Examinations and complete all other necessary procedures for licensure requirements.

I recommend this applicant based on the following:

Signature ____

SOUTH DAKOTA BOARD OF NURSING FACILITY ADMINISTRATORS
APPLICANT'S LETTER OF RECOMMENDATION
(Professional reference may not be related to the applicant by kinship or marriage)

FROM: ____

TITLE: ____

PLACE OF EMPLOYMENT: ____________________ PHONE: ____________

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ADDRESS: ______________________ ______________ ________ ______________
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I recommend this applicant based on the following:

Signature ______________________________