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 and mailing address via email to SDNFA@midwestsolutionssd.com. Completed fingerprint cards must be submitted with a $50.00 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)

Electronic Notary Statement, if applicable:

On this ____ day of _____, in the year _____, before me, _____, the undersigned office appeared _____ with a remote location of _____ (city/state), whom I have personal knowledge by identity proofing and whom I positively identified as the person whose name is subscribed to the within instrument, appeared before me not in my physical presence but by means of a tamper-evident electronic notarization system, and I observed his/her execution of the same for the purposes contained therein and confirm that I affix my official seal to the same instrument so executed.

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 _____

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