

## **SOUTH DAKOTA BOARD OF NURSING**

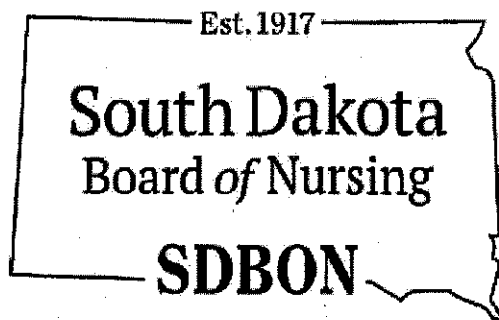
4305 S. Louise Ave., Suite 201 | Sioux Falls, SD 57106-3115  
605-362-2760 | <https://doh.sd.gov/boards/nursing/>

**DRAFT COPY**

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For more information and the link to the Clinical Enrichment Program online application, please e-mail **Glenna Burg**, Nursing Education Consultant.



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**4305 S. LOUISE AVENUE**  
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**SIOUX FALLS, SD 57106**  
**605.362.2760**

**Clinical Enrichment Program (CEP) Initial Request for Approval**

**1. Institution/Agency Information**

**\* 1. Enter the Institution/Agency information below.**

**Institution/Agency Name**

**Mailing Address**

**Address 2**

**City**

**State**

**ZIP Code**

**Phone Number**

**\* 2. The Program Coordinator must be a registered nurse with a current South Dakota license [ARSD 20:48:07.01:02(5)] Enter the Program Coordinator's information below.**

**Program Coordinator Name**

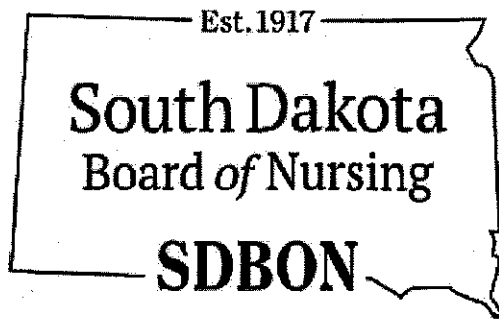
**Credentials**

**RN License Number**

**Email Address**

**Phone Number**

**3. Enter the name and credentials of person completing form, if different from above.**



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**2. Program Information**

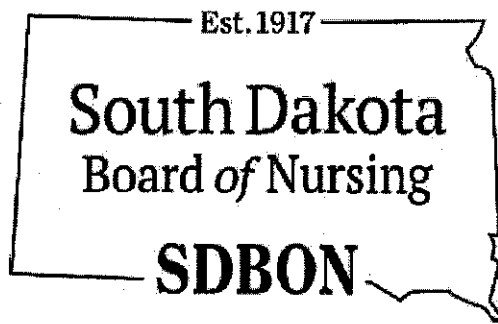
\* 4. How many student employees does your institution/agency plan to hire each year?

0 50

\* 5. What is the proposed length of the program?

\* 6. Does your institution/agency plan to offer multiple sessions per year?

- ☐ Yes
- ☐ No



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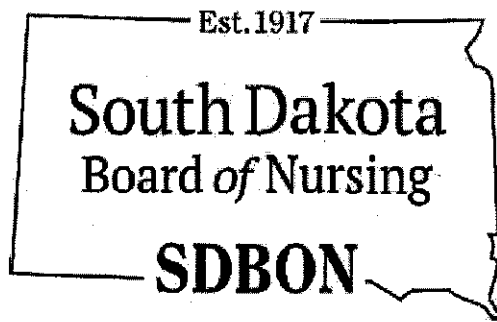
**3. Program Information - Multiple Sessions**

\* 7. How many sessions will be offered each year?

2 ☐ 5 ☐

\* 8. List approximate dates of each session. For example: Fall, Spring, Summer OR May-August, September-December, January-April.

Session 1	<input type="text"/>
Session 2	<input type="text"/>
Session 3	<input type="text"/>
Session 4	<input type="text"/>
Session 5	<input type="text"/>



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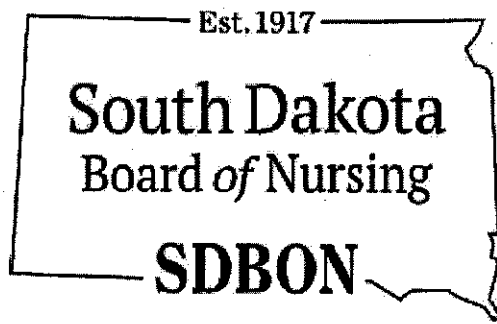
**4. Institution/Agency Criteria**

*\* 9. The institution/agency must be licensed or approved by local or state agencies or governing bodies. [ARSD 20:48:07.01:02(1)] List the licensing, approving, and/or governing bodies below.*

*\* 10. The institution/agency must submit a written philosophy - an expression of the institution's/agency's belief about nursing and its role in the education of nurses. [ARSD 20:48:07.01:02(2)] Enter the philosophy below.*

*\* 11. The institution/agency must have the facilities available to achieve the objectives. [ARSD 20:48:07.01:02(3)] Describe briefly the facilities that are available below.*

*\* 12. The institution/agency must have written admission criteria for student employees. [ARSD 20:48:07.01:02(9)] Describe the criteria below.*



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**5. Objectives**

***The institution/agency must have measurable program objectives. [ARSD 20:48:07.01:02(2)] AND The institution/agency must have a plan to achieve the objectives. [ARSD 20:48:07.01:02(4)] Enter up to FIVE measurable student-centered objectives and the associated student learning activities below. For example:***

***Objective 1 with Learning Activities***

***The student will perform selected nursing procedures and treatments.***

- A) Monitor IV sites, dressings, and rates;***
- B) Change dressings;***
- C) Document care provided.***

***13. Objective 1 with Learning Activities***

***14. Objective 2 with Learning Activities***

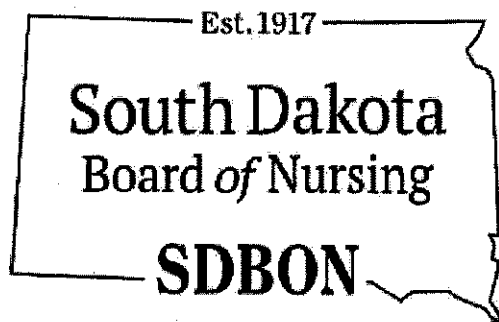
***15. Objective 3 with Learning Activities***

***16. Objective 4 with Learning Activities***

17. Objective 5 with Learning Activities

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#### 6. Preceptor Criteria

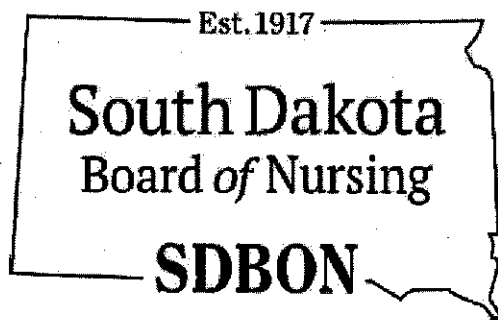
18. *Preceptors must be registered nurses with current South Dakota licenses and have at least one year of successful clinical experience. [ARSD 20:48:07.01:02(6)]* If preceptors have not been selected, describe how qualifications and licensure requirements will be assured below. **If preceptors have already been selected, submit a list of preceptors, RN license numbers, and years of experience to [Glenna.Burg@state.sd.us](mailto:Glenna.Burg@state.sd.us)**

\* 19. *Responsibilities of instructional staff (preceptors) must be documented. [ARSD 20:48:07.01:02(7)]* List the responsibilities below.

\* 20. *There must be a plan for orientation of instructional staff (preceptors). [ARSD 20:48:07.01:02(7)]*  
Describe the orientation plan below.

\* 21. *The preceptor/student employee ratio for the clinical setting must be 1:1. [ARSD 20:48:07.01:02(8)]*  
Describe how the 1:1 ratio will be assured below.





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### **Clinical Enrichment Program (CEP) Initial Request for Approval**

#### **7. Evaluation Criteria**

***The evaluation tool(s) must enable the preceptor and the student employee to determine the extent to which the objectives were met. [ARSD 20:48:07.01:02(10)] Submit copies of the evaluation tool(s) to Glenna.Burg@state.sd.us***

**At a minimum, the evaluation tools should evaluate how each objective was met from both the student and preceptor perspective. For example:**

**Objective 1 - The student will perform selected nursing procedures and treatments.**

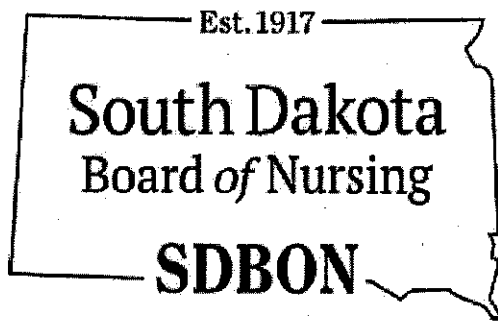
**5 - Strongly Agree**

**4 - Agree**

**3 - Neutral**

**2 - Disagree**

**1 - Strongly Disagree**



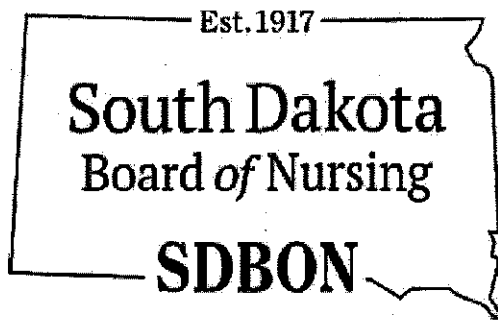
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8. Additional Comments

22. Enter any additional comments or explanations here.

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**9. Attestation**

\* 23. By submitting this CEP approval request, I declare and affirm that my responses are, to the best of my knowledge and belief, true and correct.

Date

Date

MM/DD/YYYY

Time

AM/PM

hh

mm

-

AM/PM