Est. 1917
South Dakota Board of Nursing
SDBON

# SOUTH DAKOTA BOARD OF NURSING

4305 S. Louise Ave., Suite 201 l Sioux Falls, SD 57106-3115
**P:** 605-362-2760 **l** sduap@state.sd.us **l** **https://doh.sd.gov/boards/nursing/**

## CNA Lapsed Reinstatement Application

**Directions**: A Certified Nurse Aide (CNA) whose registry status has expired, and who meets the *required minimum of 12 hours of training per year and 12 hours of employment performing nursing or nursing-related services for monetary compensation during the preceding 24 months*, may request to be reinstated to an active status by submitting this application to the Board of Nursing. Allow ***5-7 business days*** for processing; then verify registry status on the Board's website.

---

**Name:** First_____ Middle_____ Last _____

**Other names used:**_____

**Mailing Address:**_____ City_____ State_____ Zip_____

**Telephone**: Home: (___)_____ Cell: (___)_____ Other: (___)_____

**Email**: _____

**CNA Registry #:**_____ **Expiration Date:**_____

---

**Disciplinary Questions:** ***If "YES"*** *is answered to any question, attach a detailed explanation and copies of charges or citations and ALL communication (to and from) with the citing agency AND the court jurisdiction, also include evidence of completion/compliance with court requirements.*

| | | | |
|---|---|---|---|
| **1.** | Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations that have not previously been reported to the Department of Health? | ☐ Yes | ☐ No |
| **2.** | Have you ever had an allegation against you for abuse, neglect, or misappropriation of property? | ☐ Yes | ☐ No |
| **3.** | Do you have a record of abuse, neglect, misappropriation, or is there any pending action of abuse, neglect, or misappropriation? | ☐ Yes | ☐ No |
| **3.** | Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? | ☐ Yes | ☐ No |
| **4.** | Are you currently being investigated or is disciplinary action pending against any 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, placed on probation, or otherwise subjected to any type of disciplinary action? | ☐ Yes | ☐ No |
| **6.** | Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital, nursing facility, or other healthcare provider entity? | ☐ Yes | ☐ No |
| **7.** | Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership? | ☐ Yes | ☐ No |
| **8.** | Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care? | ☐ Yes | ☐ No |
| ***9.*** | *Do you currently owe child support arrearages in the amount of $1,000 or more?* | ☐ *Yes* | ☐ *No* |
| ***10.*** | *Have you ever had action taken against you by the Office of Inspector General (OIG)?* | ☐ *Yes* | ☐ *No* |

***Employment Questions: If "YES"*** *is answered to both questions, have your current or previous employer complete the* ***Employer Verification*** *below, then send the completed application to the Board office.* ***If "NO"*** *is answered to either question, stop, complete the CNA Reinstatement Application: Competency Evaluation Program Required.*

| | | | |
|---|---|---|---|
| **1.** | During the preceding 24 months, have you been employed a minimum of 12 hours performing nursing or nursing-related services for monetary compensation? | □ Yes | □ No |
| **2.** | During the preceding 24 months, have you completed a minimum of 12 hours per year (24 hours total) of in-service education related to the results of a performance review or on resident needs? | □ Yes | □ No |

***I declare and affirm that, to the best of my knowledge and belief, all information provided on this application is complete, true, and correct.***

***CNA Signature:*** _____ ***Date:***_____

Est. 1917
South Dakota Board of Nursing
SDBON

**SOUTH DAKOTA BOARD OF NURSING**

4305 S. Louise Ave., Suite 201 l Sioux Falls, SD 57106-3115
**P:** 605-362-2760 **l** sduap@state.sd.us **l https://doh.sd.gov/boards/nursing/**

# Employer Verification

**Name of Employer:** _____

**Employer Representative Name/Title (Please Print):** _____

**Address:** _____

**City, ST, Zip:** _____

**Telephone:** _____

**Employer Representative:** *Respond to these questions to the best of your knowledge.*

| | | |
|---|---|---|
| 1. Does this applicant have a record of abuse, neglect, misappropriation, or any pending action of abuse, neglect, or misappropriation? | □ Yes | □ No |
| 2. Has this applicant, during the preceding 24 months, been employed a minimum of 12 hours performing nursing or nursing-related services for monetary compensation? | □ Yes | □ No |
| • If yes, provide the total number of hours: | | |
| 3. Has this applicant during the preceding 24 months, completed a minimum of 12 hours per year (24 hours total) of in-service education related to the results of a performance review or on resident needs? | □ Yes | □ No |

*I declare and affirm that, to the best of my knowledge, all information provided on this Verification is complete, true, and correct.*

***Signature of Employer Representative:*** _____

**Date:** _____

***All questions must be answered, an incomplete application will result in a delay in processing!***

***Email completed application to sduap@state.sd.us***
*Or mail to the address listed at the top of this application.*