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 Waiver Application

- This application is **ONLY** for individuals who are **NOT** administering medications to clients in a skilled nursing facility, assisted living center, or hospital.
- Send completed application to the SDBON office with requested documentation to support your request to waive the 16 hours of medication administration training.
- *All applicants* must complete the MATP's 4 hours of clinical/lab instruction, a competency evaluation, and pass the MATP's final exam.

First Name:_____ Middle Initial:_____ Last Name:_____

Other Names Previously Used: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

- If you are a **Nursing Student,** submit the following to the Board:
  - ☐ This application, and
  - ☐ A copy of transcript, grade report, or other documentation, from your nursing education program that verifies successful completion of a **Pharmacology course** and a **Fundamentals in Nursing course** that includes theory, lab, and clinical in the area of medication administration.

- If you are **Endorsing as a Medication Aide from Another State**: You must have completed a high school education or GED. Submit the following to the Board:
  - ☐ This application;
  - ☐ Documentation to support current registration on another state's medication aide registry or employment as a medication aide for a minimum of 12 hours during the preceding two years;
  - ☐ Documentation to support completion of another state's medication training program that was a minimum of 20-hours in length.

- If you hold an **Inactive LPN or RN license**, submit this application and the following information:

  License Number: _____ State: _____ Expiration Date: _____

  The SDBON will verify the license. If a nurse has had disciplinary action, the Board will review and determine whether or not medication administration tasks may be delegated to this individual.

NOTICE *of approval/denial will be emailed to the RN instructor listed below within 5 – 7 business days.*

Provide the MATP RN Instructor contact information:

First Name:_____ Last Name:_____

Phone:_____ Email: _____