Est. 1917
South Dakota Board of Nursing
SDBON

SOUTH DAKOTA BOARD OF NURSING

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

General Instructions for Licensure by Endorsement
Certified Nurse Practitioner

Please follow instructions carefully to avoid delays in processing your application. If any information on your application is incorrect, incomplete or illegible, processing of the application may be delayed. You can expect that it will take 4 – 6 weeks before all forms are received by the Board office, upon receipt of all forms your application will be considered for approval. You will be notified in writing that your application has been approved.

Application and Fees

Complete general application Form 1 and return to South Dakota (SD) Board of Nursing (BON) office. The fee for licensure is $100 and must accompany application. Fee payment should be in the form of a money order payable to SD Board of Nursing. An application is null one year following the date it was received at the Board office. Fees are non-refundable. If a Temporary Permit is also desired, see Temporary Permit below.

Registered Nurse License

You must hold an active, unencumbered SD RN license or temporary permit; *or* hold a compact RN license with multi state privilege to practice. If you do not hold a SD RN license, or a compact license, you must apply for SD RN licensure. Complete the RN Application for Licensure by Endorsement.

Criminal Background Check

Pursuant to SDCL 36-9A-9.1 **each** applicant for licensure must submit a full set of fingerprints to obtain a state and federal criminal background check (CBC).

The fingerprint card packet and instructions will be mailed to the address provided on your application.

- Your application for temporary permit will **not** be issued until your completed fingerprint cards are received.
- Permanent licensure will not be issued until the results of your criminal background check are received by the Board office.

Request for Transcript

Submit a transcript from **each** college, university, or program you attended, or completed course work at, that pertains to your nurse practitioner (NP) education. The college/program that issued your degree must include the date the degree was conferred/awarded or post-graduate certificate awarded, the NP role, and the population focus area(s). Copies of transcripts are not accepted. *You may choose to*:

1. Complete the college's online transcript request process, have the transcript electronically sent directly to sdbon@state.sd.us
2. *OR* – Complete the Transcript Request Form 2 and send to the college's Office of the Registrar. The Registrar must send the official transcript(s) directly to the SD BON office.

Certification Verification

Primary source verification of successfully passing an NP certification examination offered by the American Academy of Nurse Practitioners – Certification Board (AANP-CB), American Nurses Credentialing Center (ANCC), American Association of Critical-Care Nurses (AACN), National Certification Corporation (NCC), or the Pediatric Nursing Certification Board (PNCB) and maintaining current certification is required for licensure and renewal. Refer to the certification organizations websites to request primary source verification of your certification status be sent directly to the Board office.

Practice Verification

All applicants for licensure are required to practice a minimum of 1,040 hours as a *licensed* NP to practice without a collaborative agreement. Pursuant to ARSD 20:62:02:02, the 1,040 practice hours must be in the role of a licensed nurse practitioner within the preceding five years. Applicants may count licensed practice hours from other jurisdictions/states. Submit the Practice Verification Form 3 to verify licensed practice hours.

If you cannot verify 1,040 hours of licensed practice you are required to submit a Collaborative Agreement with a SD licensed physician or SD licensed CNP. The physician or CNP must have a minimum of 2 years of licensed practice experience, hold an unencumbered SD

license, and practice in a comparable area to your NP education and certification. Once you have met the minimum 1,040 hours of practice you may complete the Practice Verification Form 3 to request retirement of the Collaborative Agreement.

Advance Practice Nursing Functions and Scope

Once licensed, an NP is permitted to practice the scope defined in SDCL 36-9A-12 and shall collaborate with other health care providers and refer or transfer patients as appropriate as required in SDCL 36-9A-13.1.

As outlined in SDCL 36-9A-12, upon licensure, CNPs may prescribe, procure, furnish, and administer over-the-counter, legend, and controlled substance drugs, schedules II-IV, according to federal and state registration requirements. Additionally, ARSD 20:62:03:11 provides further clarification on prescribing requirements.

Temporary Permit

To practice as an NP in SD, you must possess a temporary permit, or a permanent license issued by the SD Board of Nursing authorizing your practice. A temporary permit is required *before* you can begin orientation at your place of employment. The permit is valid only for the period it has been issued and may not be renewed. Practice beyond the expiration date is a violation of law and may result in disciplinary action. The holder of a permit to practice will use the designation of **CNP-app** after name.

1. A **temporary permit by endorsement** is issued to an applicant who holds licensure as an NP in another state or territory and is awaiting licensure in SD. The permit becomes invalid *120 days* from issuance date. The temporary permit will be issued when the following is completed and received in the Board office:

    a. General Application – Form 1 with $100 fee.
    b. Temporary Permit Application – Form 4 with $25 fee.
    c. Fingerprint cards (see Criminal Background Check)
    d. Verification of current RN licensure.
    e. Verification of current NP licensure in another jurisdiction/state.
    f. Verification of current certification in role of NP. Provide a copy of your current certification card from AANP-CB, ANCC, AACN, NCC, or PNCB – *Or* – have primary source verification of current certification sent directly from the certification organization.
    g. Submit Practice Verification Form 3. Applicants are required to practice a minimum of 1,040 hours as a licensed CNP to practice without a collaborative agreement. *If you cannot verify 1,040 hours of licensed practice* complete and submit a Collaborative Agreement with a SD licensed physician or SD licensed CNP.

SOUTH DAKOTA BOARD OF NURSING

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

Certified Nurse Practitioner
General Application – Form 1

Please Print

Name: First_____ Middle_____ Last _____

Maiden Name:_____ Other Name (s):_____

Home Address:_____ City_____ State_____ Zip_____
Street/PO Box

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

Email: _____

Date of Birth:_____ **Social Security Number**: _____

US Citizen: ❑Yes ❑No **Gender**: ❑Male ❑Female

Race/Ethnicity: ❒American Indian/Alaskan Native ❒Asian ❒Black / African American ❒Hispanic / Latino

❒Native Hawaiian / Other Pacific Islander ❒Other ❒White /Caucasian

---

Declaration of Primary State of Residence:

- I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is: _____ This is my "home state" under the Nurse Licensure Compact and is my declared fixed permanent and principal home for legal purposes.
- Provide RN License # in primary state of residence:_____.
- Are you employed by the federal government? ❑ Yes ❑ No
  .

---

1. Information regarding your **RN** education:

Institution Name	Location (City, State)	Completion Date	Degree Received: (e.g. diploma, AD, BS)

2. Information regarding your **NP** education:

Institution Name	Location (City, State)	Completion Date	Degree Received: (e.g. MS, Post Certificate, DNP)

3. Have you been authorized to practice as a Nurse Practitioner (NP) in another state? ❑Yes ❑No

4. NP licensure history*:

State	Licensed Title	License #	Date Issued	Expiration Date

*You may also submit a separate document listing this information.

5. Indicate current NP national certification(s) that you hold or will be obtaining:

- ❑ Acute Care
- ❑ Adult
- ❑ Adult-Gerontology Acute Care
- ❑ Adult-Gerontology Primary Care
- ❑ Family Across the Lifespan
- ❑ Gerontology
- ❑ Neonatal
- ❑ Psych-Mental Health Across the Lifespan
- ❑ Pediatric Acute Care
- ❑ Pediatric Primary Care
- ❑ Women's Health

6. Provide information regarding your NP certification(s) from AANP-CB, ANCC, AACN, NCC, or PNCB. *

Certification Body	Certification #	Date Issued	Expiration Date	Pending certification (as applicable)
				Exam date:
				Exam date:

* Request primary source verification of your certification status be sent directly to the Board office; refer to the certification organizations websites and request verification be emailed to: sdbon@state.sd.us

Compliance Information:

1.	Have you 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? **If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.**	❑YES	❑NO
2.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	❑YES	❑NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	❑YES	❑NO
4.	Has any nursing 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
5.	Have you had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	❑YES	❑NO
6.	Have you been treated for abuse or misuse of any alcohol or chemical substance?	❑YES	❑NO
7.	Are you currently enrolled in an Alternative to Discipline Program?	❑YES	❑NO
8.	Have you 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 sum of $1,000 or more?	❑YES	❑NO
For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.			

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Applicant Signature _____ Date _____

SOUTH DAKOTA BOARD OF NURSING

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

Certified Nurse Practitioner
OPTIONAL **Transcript Request – Form 2**

This form is optional. If the college offers online transcripts you may choose to request an online transcript be sent to the Board office. Request the transcript be electronically sent directly to: sdbon@state.sd.us

Applicant: complete this form for *each* college, university, or program you completed coursework from that prepared you for your CNP role. The college that awarded/conferred your graduate nursing degree should include the date the degree was awarded/conferred.

Contact the Registrar's Office(s) to determine the appropriate fee to enclose for transcript/document service. The Registrar must send the official transcript(s) directly to the SD BON office.

Forward this form to the Office of the Registrar.

Please Print

1. Name: First_____ Middle_____ Last _____

2. Maiden and Other Names Previously used:_____

3. Address:_____ City_____ State_____ Zip_____
   Street/PO Box

4. Date of Graduation:_____ Social Security #:_____

I am requesting an official transcript (must bear raised or color-coded school seal and evidence of the degree conferred and date conferred) of my nursing education be attached to this request and forwarded to the South Dakota Board of Nursing for licensure purposes.

_____ _____
Applicant Signature Date

REGISTRAR:
Please return this form with the official transcript and
send to the South Dakota Board of Nursing at the address above.

SOUTH DAKOTA BOARD OF NURSING

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

CNP Practice Verification – Form 3

All applicants for licensure are required to practice a minimum of 1,040 hours as a *licensed* CNP to practice without a collaborative agreement. *If you cannot verify 1,040 hours of licensed practice,* submit a completed Collaborative Agreement with a SD licensed physician or SD licensed CNP.

Return this completed form via email (sdbon@state.sd.us) or mail to the SD Board of Nursing.

Name: First_____Middle_____Last _____

Social Security #: _____

Telephone: (___) _____ **Email**: _____

I, hereby request and authorize my employer / former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

_____ _____
Signature Date

This section to be completed by Employer / Agency Representative:
(Provide Employment Hours Within the Preceding 5 Years)

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the above-named individual has practiced in the role of a **licensed** CNP:

From _____
Month/Date/Year

To _____
Month/Date/Year

Total number of hours: _____

I, the undersigned, declare and affirm the information provided above for purpose of licensure is true and correct.

_____ _____
Signature of Agency Representative/Title Date

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip Code:_____

Telephone: _____

SOUTH DAKOTA BOARD OF NURSING

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

Certified Nurse Practitioner
Temporary Permit Application – Form 4

Please Print

Name: First_____Middle_____Last _____

❑ I request a **temporary permit by endorsement.**

I hold a license as a CNP in another state or territory and have applied for and am awaiting licensure in SD.

Requirements:
- Meet all requirements listed in the General Instructions, page 2.
- Verify practice:
  - Submit Practice Verification Form 3 with minimum of 1,040 hours of *licensed* practice as a CNP; **or**
  - Submit a signed Collaborative Agreement with a South Dakota licensed physician or CNP,

The permit will be issued after all requirements are met:
- The holder of a temporary permit to practice will use the designation of **CNP-app** after his/her name.
- The permit becomes invalid 120 days from issuance date.

I, the undersigned, declare and affirm under the penalties of perjury that this application for temporary permit in the state of South Dakota has been examined by me, and to the best of my knowledge and belief is in all things true and correct.

_____ _____
Applicant Signature **Date**

SOUTH DAKOTA BOARD OF NURSING

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

Agreement must be approved prior to practice. Submit completed agreement to the Board of Nursing by email (PDF) to sdbon@state.sd.us or mail original document to the SD Board of Nursing office.

Once the approval process is completed:

- Other interested parties/employers may access the approval notice posted on the Board of Nursing's Online Verification website under the CNP's name: https://www.sdbon.org/verify/.

After the New CNP has practiced at least 1,040 hours of licensed CNP practice, the CNP may submit the Practice Verification Form to request this agreement be retired.

Advance Practice Registered Nurse

Certified Nurse Practitioner Collaborative Agreement

Between_____**,** hereinafter referred to as **New CNP**, and

_____, hereinafter referred to as **Physician/CNP**.

Whereas, a Certified Nurse Practitioner (CNP) license is required to practice in the role of a Nurse Practitioner (NP) in South Dakota (SD) as provided for under SDCL Chapter 36-9A, as administered by the SD Board of Nursing. **Whereas**, the scope of practice listed in SDCL 36-9A-12 may be performed by a CNP in collaboration with a licensed physician or CNP as defined in SDCL 36-9A-4 when licensed without the minimum 1,040 hours of licensed practice as a CNP.

Now, therefore, it is agreed between the Physician/CNP and the New CNP:

The New CNP Licensee may perform such services as are allowed by SDCL 36-9A-12 and not expressly excluded by SDCL Chapter 36-9A for which educational and clinic competency has been demonstrated in a manner satisfactory to said Board.

36-9A-12. In addition to the registered nurse scope of practice, as defined in § 36-9-3, and within the certified nurse practitioner role and population focus, a certified nurse practitioner may perform the following advanced practice registered nursing scope:

(1) Conduct an advanced assessment;
(2) Order and interpret diagnostic procedures;
(3) Establish primary and differential diagnoses;
(4) Prescribe, order, administer, and furnish therapeutic measures as follows:
  (a) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources;
  (b) Prescribe, procure, administer, and furnish pharmacological agents, including over the counter, legend, and controlled drugs or substances listed on Schedule II in chapter 34-20B;
  (c) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including durable medical equipment, medical devices, nutrition, blood and blood products, diagnostic, and supportive services including home health care, hospice, and physical and occupational therapy; and
  (d) Write a chemical or physical restraint order when the patient may do personal harm or harm others;
(5) Perform a physical examination for the determination of participation in athletics or employment duties;
(6) Complete and sign official documents such as death certificates, birth certificates, and similar documents required by law; and
(7) Delegate and assign therapeutic measures to assistive personnel.

It is further understood and agreed by and between the parties:

A. Collaboration will occur pursuant to SDCL 36-9A-1 (6). The New CNP and the physician/CNP will communicate pertinent information and consult together on patient care, with each party contributing their expertise to optimize the overall care delivered to the patient.

B. Nothing in this agreement shall be construed to limit the responsibility of either party to the other in the fulfillment of this agreement.

C. This agreement shall not take effect until it has been filed in the office of the SD Board of Nursing and approved by the Board and shall remain in effect until the agreement is terminated in writing by the physician/CNP or New CNP.

D. The agreement shall remain in effect as long as the terms defined herein describe the New CNP's current practice unless terminated in writing by either party. Upon termination of this agreement, the New CNP may not perform the services defined in SDCL 36-9A-12 unless a new collaborative agreement is on file with the Boards or the New CNP has met 1,040 hours of licensed CNP practice.

E. It is further understood and agreed by and between the parties that any changes in the practice act subsequent to the date of this collaborative agreement will take precedence and modify the affected provision(s) of this agreement.

The parties hereto enter in this agreement:

Start Date:	_____\ _____\ _____,	End Date (if applicable):	_____\ _____\ _____.

I, the undersigned, declare and affirm under the penalties of perjury that this Collaborative Agreement 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 should I furnish any false information, such an act may constitute cause for denial of approval and discipline of my license to practice in South Dakota.

Please Print

Name of New CNP:	
Email Address:	
Signature:	

Name of Collaborating Physician or CNP:		SD License #:
Have you practiced for a minimum of 2 years as a licensed professional?	❑Yes ❑No	
Email Address:		
Signature:		

Est. 1917
South Dakota Board of Nursing
SDBON

SOUTH DAKOTA BOARD OF NURSING

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

Advance Practice Registered Nurse
Nurse Practitioner Supervisory Agreement for Temporary Permit to Practice

Whereas, a Certified Nurse Practitioner (CNP) license or temporary permit is required to practice in the role of a Nurse Practitioner (NP) in South Dakota (SD) as provided for under SDCL Chapter 36-9A, as administered by the SD Board of Nursing, hereinafter referred to as Board. **And Whereas**, the scope of practice listed in SDCL 36-9A-12 may be performed by the CNP applicant, herein referred to as CNP-App, under the supervision of a licensed physician or CNP as defined in SDCL 36-9A, while holding a temporary CNP permit.

Now, therefore, it is agreed between the physician/CNP and the CNP-App:

The CNP-App may perform such services as are allowed by SDCL 36-9A-12 and not expressly excluded by SDCL Chapter 36-9A for which educational and clinical competency has been demonstrated in a manner satisfactory to said Board.

36-9A-12. In addition to the registered nurse scope of practice, as defined in § 36-9-3, and within the certified nurse practitioner role and population focus, a certified nurse practitioner may perform the following advanced practice registered nursing scope:

1. Conduct an advanced assessment;
2. Order and interpret diagnostic procedures;
3. Establish primary and differential diagnoses;
4. Prescribe, order, administer, and furnish therapeutic measures as follows:
   a) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources;
   b) Prescribe, procure, administer, and furnish pharmacological agents, including over the counter, legend, and controlled drugs or substances listed on Schedule II in chapter 34-20B;
   c) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including durable medical equipment, medical devices, nutrition, blood and blood products, diagnostic, and supportive services including home health care, hospice, and physical and occupational therapy; and
5. Write a chemical or physical restraint order when the patient may do personal harm or harm others;
6. Perform a physical examination for the determination of participation in athletics or employment duties;
7. Complete and sign official documents such as death certificates, birth certificates, and similar documents required by law; and
8. Delegate and assign therapeutic measures to assistive personnel.

It is further understood and agreed by and between the parties:

1. The CNP-App and Physician/CNP shall be subject to **thirty days of on-site, direct supervision** by the Physician/CNP. Thereafter the direct supervision shall include two, one-half business days per week of on-site supervision by a supervising physician/CNP.
2. Nothing in this agreement shall be construed to limit the responsibility of either party to the other in the fulfillment of this agreement.
3. In the event the Board puts a restriction upon the services that may be performed by the CNP-App, as a condition precedent to licensure, the Physician/CNP hereby waives any objection to the CNP-App's failure to perform tasks not permitted by said Board.
4. This agreement shall not take effect until it has been filed in the SD Board of Nursing office and approved by the Board and shall remain in effect until the temporary permit becomes invalid or unless terminated in writing by the physician/CNP or CNP-App.

NAME OF PRACTICE SETTING:	ADDRESS:	PHONE NUMBER:
1.		
2.		

The parties hereto enter in this agreement on: _____/_____/_____

I, the undersigned, declare and affirm under the penalties of perjury that this Supervisory Agreement 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 should I furnish any false information, such an act may constitute cause for denial of approval and discipline of my license to practice in SD.

CNP-App Name:	
Email Address:	
Signature:	

Supervising Physician / CNP Name:		SD LICENSE #:
Have you practiced for a minimum of 2 years as a licensed professional?	❑Yes ❑No	
Email Address:		
Signature:		