



South Dakota Board of Nursing Facility Administrators

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APPLICATION FOR CERTIFIED PRECEPTOR

Name: _____ License #: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Employer Office: _____ Phone: _____

Physical Address: _____ Mailing address: _____

City: _____ State: _____ Zip: _____

Have you been licensed as a Nursing Facility Administrator in South Dakota for at least four years?

Yes No Date of South Dakota Licensure: _____

Do you currently or have you ever held a license issued by a different state or the District of Columbia to practice as nursing facility administrator? Yes No

Has any nursing facility administrator 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

If yes, please attach a detailed explanation with this application. You must also submit copies of all communications (to and from) the citing agency or board, including evidence of completion/compliance with requirements. 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.

Signature: _____ Date: _____

Printed Name: _____

For Office Use Only:

Date of original South Dakota licensure: _____

Disciplinary history: ____ Yes ____ No

If yes, type of discipline and date: _____