South Dakota Board of Nursing Facility Administrators
P.O. Box 340, 1351 N. Harrison Ave. Pierre, SD 57501-0340
Ph.: 605-224-1721 Fax: 888-425-3032
E-mail: SDNFA@midwestsolutionssd.com http://nursingfacility.sd.gov

APPLICATION TO REACTIVATE LICENSE

Please submit the following:

1. Completed application;
2. Nonrefundable application fee of $390 and $100 state examination fee;
3. If applicable, a verification letter from each state in which you have been registered;
4. If applicable, verification of any name change; and
5. Verification of 20 hours of approved continuing education earned within the past 12 months.

Name: _____ E-mail: _____ Phone: _____

Address: _____SSN:_____DOB:_____

City: _____ State: _____ Zip: _____

Employer Office: _____ Phone: _____

Physical Address: _____ Mailing address: _____

City: _____ State: _____ Zip: _____

Inactive SD License: License #:_____Year Inactivated: _____

Reason for request to reactive your license:

Please answer the following questions:

1. Are you the spouse of a member of the armed forces of the United States? ☐ Yes ☐ No
   a. If yes, was your spouse the subject of a military transfer to South Dakota and did you leave employment to accompany your spouse to South Dakota? ☐ Yes ☐ No
2. Do you currently hold a valid license issued by a different state or the District of Columbia to practice as a Nursing Facility Administrator? ☐ Yes ☐ No

If applicable, please submit the following information for each state in which you have been licensed. *You must also submit a certified letter verifying the license number and status of your license from the board of nursing facility administrators in each state in which you have been licensed.* ***These letters must be sent directly to our office***.

STATE_____LICENSE #_____DATE RECEIVED_____STATUS_____
STATE_____LICENSE #_____DATE RECEIVED_____STATUS_____

3. Do you practice as a Nursing Facility Administrator:
   ☐ Full-Time ☐ Part-Time ☐ Temporary ☐ Retired/Not Working

CRIMINAL HISTORY	(circle one)
1. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence, or had prosecution deferred with respect to a felony? **If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communications (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements. You must attach all communications for a violation to the signed and dated explanation of that violation. Please put correspondence in chronological order (most recent first). If you have more than one violation, please do the same for each violation.**	☐ Yes ☐ No
2. Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence, or had prosecution deferred with respect to a misdemeanor other than a class 2 misdemeanor traffic offense?	☐ Yes ☐ No
3. Is there any pending criminal prosecution against you?	☐ Yes ☐ No
4. Are you currently being investigated or is disciplinary action pending against any professional 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, or have you been placed on probation or otherwise subjected to any type of disciplinary action?	☐ Yes ☐ No
6. Have you ever been denied a license to practice in another state?	☐ Yes ☐ No
7. Have you ever appeared or been requested to appear before any licensing board concerning any violation of law or regulation of any state district, territory or province of the United States or Canada?	☐ Yes ☐ No
8. Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	☐ Yes ☐ No
9. Have you ever been subject to proceedings by a professional society to revoke, reduce or restrict membership?	☐ Yes ☐ No
10. Have you ever received care or treatment for abuse or misuse of alcohol or any chemical substance?	☐ Yes ☐ No
11. Have you ever received care or treatment for an emotional or mental condition or illness?	☐ Yes ☐ No
12. Do you currently owe child support arrearages in the amount of $1,000 or more?	☐ Yes ☐ No
13. Were you subject to any ethical violations while enrolled in school?	☐ Yes ☐ No
14. Have you ever been released from the military by any means other than an honorable discharge?	☐ Yes ☐ No
15. Are you in any way using fraud or deception in applying for a license to practice in South Dakota?	☐ Yes ☐ No
For 2-15 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and events. You must also send ALL supporting applicable documents. You must attach supporting documents to the signed and dated explanation. Please put supporting documents in chronological order (most recent first).	

Continuing Education – *Please provide information regarding the 20 hours of approved continuing education earned within the past 12 months. You may be required to provide verification of attendance for each course.*

Program Date	**Program Name**	**Approved Sponsor or Approval Code**	**Approved Hours**

State Examination: The South Dakota State exam is administered online and activated by the Board. When you submit this application with the required fee, the Board will activate your exam and an email containing the examination access information will be automatically sent to the email provided on this application. *An applicant who has failed the state examination is entitled to reexamination a maximum of three times upon payment of the applicable fees. If unsuccessful after four attempts, the applicant may petition the board for reconsideration.*

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. I am aware that any misstatements of material facts may cause rejection of my application. I have no objection to inquires being made for the purpose verifying the statements made herein.

_____ _____

Signature of Applicant Date

Sworn to and before me this _____ day of _____, 20_____

_____ My commission expires:

Notary Signature

(SEAL)

Mail completed application, verification letters, continuing education documentation and fees to:
South Dakota Board of Nursing Facility Administrators
PO Box 340
Pierre, SD 57501

For Office Use Only: Check # _____ *Amount* _____ *Date* _____