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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 **https://doh.sd.gov/boards/nursing/**

UMA Waiver Application

ALL applicants must complete the 4 hour lab/clinical portion of the Medication Aide Training Program and pass the SDBON exam.

RNs and LPNs with active licenses can practice under their nursing license and do not need to be listed on the UMA registry.

If any of the information is incorrect, incomplete or illegible, processing may be delayed. An applicant will be notified if additional information is required. E**mail this completed application to sduap@state.sd.us. *Allow up to 5-7 business days*** *for the SDBON to process your application. Upon approval the BON will email the approved proctor the access information to allow you to take the SDBON online exam.*

Please Print

Name: First_____Middle_____Last _____

Other names previously used:_____

Mailing Address:_____City_____State_____Zip_____
Street/PO Box

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

Email: _____**Date of Birth**:_____

Social Security #: _____ **Gender**: ❑Male ❑Female

Ethnicity: ❑Caucasian ❑Black ❑Hispanic ❑Asian/Pacific Islander ❑American Indian/Alaskan Native ❑Other

Disciplinary Information:

Please provide details and/or documentation to explain each question with a "yes" answer. Attach additional pages to the application if needed. If further information is required, you will be notified by the South Dakota Board of Nursing.

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 that have not previously been reported to the South Dakota Board of Nursing?	□ Yes	□ No
2.	Is there any pending criminal prosecution against you which would constitute a felony?	□ Yes	□ No
3.	Have you had action taken against you for abuse, neglect, or misappropriation of property by a state or federal agency?	□ 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 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 been treated for abuse or misuse of any alcohol or chemical substance since your last renewal?	□ Yes	□ No
7.	Do you currently owe child support arrearages in the amount of $1,000 or more?	□ Yes	□ No

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1. Submit with this application:

☐ Copy of student's school transcript, grade report, or other school documentation verifying successful completion of a Pharmacology course and a Fundamentals in Nursing Course that includes theory, lab, and clinical in the area of medication administration.

- Name of Nursing School: _____

OR

☐ Provide RN/LPN license number and state/jurisdiction of that license (RNs and LPNs with **active** licenses practice under their nursing license and do not need to be listed on the UMA registry).

Number: _____ State: _____ Expiration Date: _____
(**Note:** South Dakota Board of Nursing will verify the licensure status of the nurse; if a nurse has had any disciplinary action, BON staff will review and determine whether or not the individual may be placed on the South Dakota Medication Aide Registry.)

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2. RN Attestation.

I, _____, RN verify that I completed 4-hours medication administration clinical/lab training with the individual identified on this application, that the applicant is capable of performing all the skills listed on the SD Board of Nursing's approved Skills Competency Checklist safely and competently, and that the applicant is eligible to take the medication aide exam.
RN Signature: _____ **RN License #:** _____ **Date:** _____

3. SD Board of Nursing Approved Test Proctor Information.

Name of SDBON Approved Proctor:	Proctor's Phone:	Proctor's Email Address:

4. Do you currently owe child support arrearages in the sum of $1,000 or more? ❒YES ❒NO
If YES, contact South Dakota Department of Social Services to make arrangements prior to issuance of med aide registration.

5. Affidavit
I, the undersigned, declare and affirm under the penalties of perjury that this application for registration 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.

_____ _____
Medication Aide Applicant Signature **Date**

This section to be completed by the South Dakota Board of Nursing	
Date Application Received:	Date Application Denied:
Date Approved:	Reason for Denial:
Board Representative:	Date Notice Sent to Student and / or Nursing Facility: