



SOUTH DAKOTA BOARD OF NURSING

4305 S. Louise Ave., Suite 201 | Sioux Falls, SD 57106-3115
(p) 605-362-2760 | <https://doh.sd.gov/boards/nursing/>

Clinical Nurse Specialist

General Instructions for Licensure Application

Please follow instructions carefully to avoid delays in processing your application. If any of the 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 if additional information is required or that your application has been approved.

Application and Fees

1. Complete general application [Form 1](#) and return to South Dakota (SD) Board of Nursing (BON) office.
2. 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

1. You must have a current, valid, unencumbered SD RN license or temporary permit.
 - If not, complete [RN Application for Licensure by Endorsement](#); www.doh.sd.gov/boards/nursing
2. Or – provide the license number of a compact RN license from your primary state of residence (where you hold a driver's license, pay taxes, and/or vote).
 - SD is a member of the Nurse Licensure Compact, for more information on the Nurse Licensure Compact see www.ncsbn.org.

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 Form

Submit a transcript from each applicable college, university, or program that you attended and completed course work at for your clinical nurse specialist role. The college that issued the degree must include the date the degree was conferred or awarded and the APRN role and population focus area you were prepared. You may choose to:

1. Complete the Transcript Request [Form 2](#) and send to the Office of the Registrar. Contact the Registrar's Office 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. (Copies of transcripts are not accepted.) Or,
2. Complete the college's online transcript request process, have the transcript electronically sent directly to: sdbon@state.sd.us

Education Verification

1. You complete applicant section of the Education Verification [Form 3](#); send a copy to each applicable college, university, or program from which you were awarded a graduate or post graduate certificate nursing degree.
2. The Dean/Director of the program, or designated official, completes remaining questions verifying education and accreditation status of the nursing program at the time of your attendance.
3. The Dean/Director of the program, or designated official, must return form to the SD BON office.

Certification Verification

Primary source verification of successfully passing a clinical nurse specialist qualifying certification examination offered by the American Nurses Credentialing Center (ANCC) or the American Association of Critical-Care Nurses (AACN) and maintaining current certification is required for licensure and renewal in SD. Refer to the certification organizations websites to request primary source verification of your certification status be sent directly to the Board office. (Contact the Board office if you would like to petition the Board to use a different exam.)

Temporary Permit

To practice as a CNS in SD you must possess a temporary permit, or a license issued by the SD BON authorizing your practice. A temporary permit is required before you can begin orientation at your place of employment. A temporary permit is valid only for the period of time 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 temporary permit to practice will use the designation of **CNS-app** after his/her name.

1. A temporary permit by examination is issued to an applicant waiting for results of the first exam they are eligible to take after completion of an approved education program. 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. Verification of current RN licensure.
 - d. Verification of education: Completed Form 3 or Transcript verifying degree was conferred;
 - e. Verification of examination eligibility: Documentation from AACN or ANCC that you are eligible to sit for their exam or that you are awaiting the results of first exam for which you are eligible after graduation.
 - f. Fingerprint cards (see Criminal Background Check above)

2. A temporary permit by endorsement is issued to an applicant who holds licensure as a CNS in another state or territory and is awaiting licensure in SD. The permit becomes invalid *90 days* from issuance date. The temporary permit will be issued when the following is completed and received in the SD BON office:
 - a. General Application – Form 1 with \$100 fee.
 - b. Temporary Permit Application – Form 4 with \$25 fee.
 - c. Verification of current RN licensure.
 - d. Verification of current CNS licensure.
 - e. Verification of current certification in role of CNS. Provide a copy of your current certification card from AACN or ANCC – OR – have primary source verification of current certification on file with the Board sent directly from the certification organization. (Contact the Board office if you would like to petition the Board to use a different exam.)
 - f. Fingerprint cards (see Criminal Background Check above)



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Clinical Nurse Specialist General Application – Form 1

Please Print

Name: First _____ Middle _____ Last _____

Other names previously used: _____

Home Address: _____ City _____ State _____ Zip _____
Street/PO Box

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

Email: _____

Date of Birth: _____ **Place of Birth:** _____

Social Security #: _____ **US Citizen:** Yes No **Gender:** Male Female

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

1. Have you been licensed as a CNS in another state? Yes (complete question 2)
 No (skip to question 3)

2. Advanced practice licensure history:

State	Licensed as	License #	Date Issued	Expiration Date

3. Information regarding your RN and Clinical Nurse Specialist nursing education:

Institution Name	Location (City, State)	Completion Date	Degree Received: (i.e. diploma, AD, BS, MS, Post Certificate, MS, DNP)

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

- Adult Gerontology Pediatric
 Neonatal Other specialty/focus area:

5. Information regarding your national certification(s):

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

Primary source verification and maintaining current certification is required for initial licensure and renewal of license.

6. 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: _____

7. Are you employed by the federal government? Yes No
 If yes, you are not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence.

8. 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.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.	Have you had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6.	Have you had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7.	Are you currently enrolled in an Alternative to Discipline Program?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8.	Have you experienced a physical, emotional, or mental condition that has endangered or posed a direct threat to the health or safety of persons entrusted to your care or your ability to safely practice?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9.	Do you currently owe child support arrearages in the sum of \$1,000 or more?	<input type="checkbox"/> YES	<input type="checkbox"/> 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



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Clinical Nurse Specialist 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, please complete this form for each applicable college, university, or program that awarded you a graduate nursing degree or post graduate certificate which prepared you for your advanced nursing specialty role. Forward this form to the Office of the Registrar.

Please Print

1. Name: First _____ Middle _____ Last _____
2. Other names previously used: _____
3. Address: Street/PO Box _____ City _____ State _____ Zip _____
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.



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Clinical Nurse Specialist Education Verification – Form 3

Applicant, complete the top section of this form then forward to the Dean/Director of the nursing program that prepared you in the CNS role and focus area. (The nursing program should complete this form, not the Registrar.)

Please Print

Graduate Name: First _____ Middle _____ Last _____

Other names previously used: _____

Address: _____ City _____ State _____ Zip _____
Street/PO Box

Telephone: Home: () _____ Other: () _____ Email: _____

Date of Birth: _____ SS#: _____

Name of Education Program: _____

Location of Program: (City, State) _____

Date your APRN degree was conferred/awarded: _____

Consent to Release Information to the South Dakota Board of Nursing:

I have applied to the SD Board of Nursing for a CNS license in the _____ focus area. Please complete this form and forward directly to the South Dakota Board of Nursing office for licensure purposes.

Applicant Signature _____ Date _____

Nursing Program Director: Complete items below and send to the South Dakota Board of Nursing at the address/fax number listed above or email PDF document to: sdbon@state.sd.us

1. Type of NP Program (check one):

Certificate Master's Degree Post-Graduate Certificate DNP Other _____

2. The applicant was educated and prepared in the CNS role and in the following focus area(s):

Adult Gerontology Pediatric
 Neonatal Other specialty/focus area: _____

3. At the time the Applicant graduated, the graduate nursing program was accredited by:

Accreditation Commission for Education in Nursing (ACEN)
 Commission on Collegiate Nursing Education (CCNE)
 National League for Nursing Accrediting Commission (NLNAC)
 Other national nursing accreditation agency: _____

Dean/Director Signature *or* Other Designated Official/Title _____

Date _____



If School Seal is no longer available, use either Agency/Institutional Seal, or so indicate.



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Clinical Nurse Specialist Temporary Permit Application – Form 4

Please Print

1. Name: First _____ Middle _____ Last _____

2. Check type of temporary permit you are requesting:

I have applied to sit for an approved certification exam and am awaiting the results of my first exam that I am eligible to take after completing my CNS education.

I request a **temporary permit by examination;**

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

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

3. List information about each facility where you will be practicing on this temporary permit:

Name of Organization	Address (street address, city, state, zip)	Telephone Number(s)

The permit will be issued after all required forms, fees, and fingerprint cards are submitted to the Board; requirements are listed on the "General Instructions for Licensure Application", page 2.

The holder of a temporary permit to practice will use the designation of "CNS app" after name.

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