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South Dakota Board of Nursing
SDBON

SOUTH DAKOTA BOARD OF NURSING

4305 S. Louise Ave., Suite 201 | Sioux Falls, SD 57106-3115
P: 605-362-2760 | **F:** 605-362-2768 | **https://doh.sd.gov/boards/nursing/**

Nurse Aide
Application for *Faculty Changes* to a Currently Approved Training Program

To request approval of a NATP, complete and submit this application along with required documentation to the Board of Nursing by faxing to the number listed above or email to sduap@state.sd.us. Written notice of approval or denial of the application will be issued upon receipt of all required documents.

Name of Institution: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

E-mail Addresses of Primary Coordinator and/or Instructor: _____

☐ **Request New Program Coordinator** must be a registered nurse with 2 years nursing experience, at least one of which is in the provision of long-term care services. The Director of Nursing (DON) may serve simultaneously as the program coordinator but may not perform training while serving as DON. (ARSD 44:74:02:10)
☐ Attach curriculum vita, resume, or work history

Name of Program Coordinator	**RN LICENSE**			
	State	**Number**	**Expiration Date**	**Verification** *(Completed by SDBON)*

☐ **Request New Primary Instructor** as actual teacher of course material; must be a RN or LPN with 2 years nursing experience, at least one of which is in the provision of long-term care services. (ARSD 44:74:02:11)
☐ Attach curriculum vita, resume, or work history,
☐ Attach documentation supporting previous experience in teaching adults within the past 5 years or documentation of completing a course in the instruction of adults.

Name of Primary Instructor	**RN OR LPN LICENSE**			
	State	**Number**	**Expiration Date**	**Verification** *(Completed by SDBON)*

☐ **Request New Supplemental Personnel** to assist with instruction, they must have one year of experience in their respective field of practice, i.e. additional licensed nurses, social worker, physical therapist. (ARSD 44:74:02:12)
☐ Attach curriculum vita, resume, or work history.

Supplemental Personnel & Credentials	**LICENSURE/REGISTRATION**			
	State	**Number**	**Expiration Date**	**Verification** *(Completed by SDBON)*

Program Coordinator 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:
Expiration Date of Approval:	
Board Representative:	
Date Notice Sent to Institution:	