



South Dakota Board of Nursing
Unlicensed Assistive Personnel
4305 South Louise Avenue Suite 201
Sioux Falls SD 57106-3115
(605) 362-2760 Fax: (605) 362-2768

South Dakota Certified Nurse Aide (CNA) Registry By Interstate Endorsement

****Eligible ONLY if you are actively listed on another state's nurse aide registry. ****

There is **NO** processing fee for the South Dakota Registry.

Application Instructions Checklist:

All information should be printed clearly. It is your responsibility to submit the required forms.

- Complete Section A-1 (pages 2 & 3) (***nurse aide will complete this section***).
 - ❖ Once the nurse aide has completed A-1, submit application (pages 2 & 3) to the South Dakota Board of Nursing.
 - Complete Section A-2 (***nurse aide will complete this section***).
 - Send Sections A-2 & A-3 (page 4) to the state registry where you were ***first*** registered as a Nurse Aide.
 - ❖ **EXCEPTIONS:** If **Arizona, California, Colorado, Florida, Illinois, Louisiana, Michigan, Missouri, New York, or North Carolina** is your ***original*** state of CNA Registry, please send sections A-1, A-2, & A-3 directly to the South Dakota Registry.
 - Complete section A-4 (***nurse aide will complete this section***).
 - Send sections A-4 & A-5 (page 5) to your current/previous employer.
 - ❖ Once employer has completed A-5, submit application (page 5) to the South Dakota Board of Nursing.
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Please Note: Once your application has been processed and approved, no card will be mailed from the SD Board of Nursing CNA Registry.

To verify or print your registration card, use the following website:

<https://www.sduap.org/verify/>



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Application for entry on the South Dakota Nurse Aide Registry by Interstate Endorsement

- This application is required to implement programs authorized by §1819(f) and §1991(f) of Public Law 100-03, the Omnibus Budget Reconciliation Act of 1987.
- A facility shall seek information from every state registry that the facility has reason to believe has information on the individual before allowing the individual to work as a nurse aide.
- A nurse aide shall apply for endorsement through the South Dakota Board of Nursing within 30 days of employment in this state. A facility may not employ a nurse aide for more than 60 days ***unless*** the aide provides proof that endorsement has been requested.
(44:74:02:04. Multistate registry verification required)

A nurse aide seeking registry status by endorsement from another state registry shall submit to the department the following information:

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. A completed application; 2. Written documentation indicating successful completion of another state's approved nurse aide training and competency evaluation program; | <ol style="list-style-type: none"> 3. Verification of initial listing on the nurse aide registry in another state; 4. Verification of listing on a nurse aide registry from the state of most recent employment; and 5. Documentation of employment as a nurse aide within the last 24 consecutive months. |
|---|---|

Applicant Information for Interstate Endorsement

Section A-1 (nurse aide will complete this section)

Instructions:

1. Complete Section A-1 (pages 2 & 3).
 - When completing the application, **please print clearly.**
2. Sign at the bottom to verify the information is true and correct.

Note: Incomplete forms will delay your transfer to the SD Registry and be **returned to you.**

Name (first, middle, last) (no initials):		Maiden Name (if applicable):
Social Security Number :	Date of Birth (mm/dd/yy):	Other Name (if applicable):
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male Ethnicity: <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other		

Current Mailing Address (street, post office box, rural route, etc.):	Apartment #:
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City:	State:	Zip Code:
(Area Code) Home Phone Number:	(Area Code) Cell Phone Number:	Email Address:

State Originally Certified:

State Currently Employed In:



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Applicant Information for Interstate Endorsement

Section A-1 – Continued (nurse aide will complete this section)

Disciplinary Information:

If “YES” is answered to any of the disciplinary questions, please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court jurisdiction, including evidence of completion/compliance with court requirements.

1.	Have you ever 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 Department of Health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Have you ever had an allegation against you for abuse, neglect, or misappropriation of property?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	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
4.	Are you currently being investigated or is disciplinary action pending against any license(s) or certificate(s) held by you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Has any 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
6.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital, nursing facility, or other healthcare provider entity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Do you currently owe child support arrearages in the amount of \$1,000 or more?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Have you ever had action taken against you by the Office of Inspector General (OIG)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

***I declare and affirm that, to the best of my knowledge and belief,
 all of the information provided on this application is complete, true, and correct.***

CNA Signature: _____ **Date:** _____

Nurse Aide: Please send this completed form via fax, email (Ashley.Vis@state.sd.us) or mail to the South Dakota Board of Nursing.



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Verification of Registration for Interstate Endorsement

Section A-2 (nurse aide will complete this section)

Instructions:

1. Complete section A-2
2. Send this page (page 4) to the State registry were you **first** registered as a nurse aide, so they may complete Section A-3.

EXCEPTIONS: If AZ, CA, CO, FL, IL, LA, MI, MO, NY or NC is your original state of registration;
 Please send this page directly to the South Dakota CNA Registry.

Name (first, middle, last) (no initials):

Social Security Number:

Date of Birth (mm/dd/yy):

State Originally Certified:

State Currently Certified:

Current State Registry Number:

Section A-3 -- State Nurse Aide Registry Information

The State registry were you first registered as a nurse aide will complete this section

Instructions:

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Please do not remove attached documents. 2. Check or complete all items that apply. 3. Affix official agency stamp or seal. | <ol style="list-style-type: none"> 4. Have authorized person sign and date the bottom of Section A-3. 5. Return this request to the South Dakota Nursing Assistant Registry at the address above (do not return to the nurse aide). |
|--|---|

The information on this application is accurate; this person is listed on the Nurse Aide Registry in our state.

The above-named person is **not** listed on the Nurse Aide Registry in our state.

Date of Manual Skills Exam (mm/dd/yy):

Date of Written Exam (mm/dd/yy):

Is there a record of abuse, neglect, misappropriation, or pending action?

Yes (please attach copies of the documentation) No

Signature of State Nurse Aide Registry Representative

Title

Agency

State

Date

Affix State Stamp
Or Seal here.

Agency Representative: Please mail this completed form and any attachments to the South Dakota Board of Nursing (do not return to nurse aide).



Employment Verification for Interstate Endorsement

Section A-4 (nurse aide will complete this section)

Instructions:

1. Complete section A-4 and sign that the information is true and correct.
2. Send this page (page 5) to your current/previous employer, so they can complete Section A-5 (Employment Verification).
 - In order to maintain an active status on the SD Registry, you must provide documentation of employment as a nurse aide within the last 24 consecutive months.
 - ***Please note** that volunteer hours do not qualify towards employment hours.*
 - If there has been a gap of more than two years in your employment as a nurse aide, you must retrain and retest.

Name (first, middle, last) (no initials)	Other Names Used (if applicable):
Social Security Number:	Date of Birth (mm/dd/yy):

Yes No I have been employed as a nurse aide within the last 24 consecutive months.

Yes No Do you have a record of abuse, neglect, misappropriation, or is there any pending action?

<i>I authorize any facility/agency I am/was employed at to furnish the SD Nursing Aide Registry the information that they request.</i> Signature of Nurse Aide:	Today's Date:
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Section A-5 -- Employment Verification

Your current/previous employer will complete this section

Instructions:

1. Complete the following information below.
2. Once employer has completed A-5, please submit application (page 5) to the SD Board of Nursing.

DATES OF EMPLOYMENT: FROM _____ **TO** _____ (If presently employed, use "present")

Total number of hours worked during this period: _____

This nurse aide has no record of abuse, neglect, or misappropriation, nor is there any pending action.

I affirm that, to the best of my knowledge, all information provided on this verification is complete, true, and correct.

Employer:	Address:	
City, State, Zip:	Telephone:	
Signature of DON, HR Representative, or Designee:	Title:	Date:

Employer: Please send this completed form via fax, email (Ashley.Vis@state.sd.us) or mail to the South Dakota Board of Nursing.