SOUTH DAKOTA BOARD OF NURSING
4305 S. Louise Ave., Suite 201 | Sioux Falls, SD 57106-3115
605-362-2760 | https://www.sdbon.org/

Medication Administration Training Waiver Application: Registered Medication Aide

- This application is **ONLY** for individuals who will be administering medications in a skilled nursing facility, assisted living center, or hospital.
- Send this completed application to the Board office with requested documentation that supports your request to waive the sixteen-hour portion of the medication administration training program (MATP).
- *All applicants* must complete a MATP's required four-hour clinical/lab portion of the program, a skills competency evaluation, and must pass the Board's final exam.

First Name:_____ Middle Initial:_____ Last Name:_____

Other Names Previously Used: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Employment Information:

I will be employed as medication aide in a Skilled Nursing Facility, Assisted Living Center, or Hospital.	☐ Yes	☐ No
Name of employing facility:		
Do you have a record of abuse, neglect, misappropriation, or is there any pending action?	☐ Yes	☐ No

Waiver Information:

- If you are a **Nursing Student,** submit the following to the Board:
  - ☐ This application, and
  - ☐ A copy of transcript, grade report, or other documentation, from your nursing education program that verifies successful completion of a **Pharmacology course** and a **Fundamentals in Nursing course** that includes theory, lab, and clinical in the area of medication administration.

- If you hold an **Inactive LPN or RN license**, submit this application and the following information:

  License Number: _____ State: _____ Expiration Date: _____

  The SDBON will verify the license. If a nurse has had disciplinary action, the Board will review and determine whether or not medication administration tasks may be delegated to this individual.

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.

Applicant Signature: _____ **Date:** _____

RN Attestation: *I verify that if the waiver is approved, this applicant will be required to complete a four-hour clinical/lab portion of a MATP program, a skills competency evaluation, pass the Board's final exam, and be registered with the Board prior to administering medications.*

RN Signature: _____ **License #:** _____

Date: _____ **Phone:** _____ **Email:** _____

NOTICE *of approval/denial will be emailed to the RN instructor listed below within 7 business days.*