STUDENT STATUS VERIFICATION

NORTH DAKOTA BOARD OF NURSING
SFN 60216 (8/2025)

SECTION A: STUDENT APPLICANT TO COMPLETE

Student First Name	Student Last Name		
Social Security Number[1]	Date of Birth	Telephone Number	
Mailing Address	City	State	Zip Code
Email Address			

SECTION B-1: PROGRAM ADMINISTRATOR/DESIGNEE TO COMPLETE

The student named above has submitted an application to the Board of Nursing for an Unlicensed Assistive Person (UAP) or a UAP/ Medication Assistant III registration. Before the application can be considered by the Board, it is necessary that we have verification of the individual's current enrollment in an education program or in a nursing education program. Please complete the following information and return it to the North Dakota Board of Nursing.

Name of School/Program			
School/Program Address	City	State	ZIP Code
Is the student in good standing and currently enrolled in the program?	☐ Yes ☐ No		
Enrollment Date: _____	Expected Completion Date: _____		

Complete only one of the following sections (check the section that applies to the student/applicant):

- If the student is a **Student Medical Assistant, Student Dialysis Technician, or Student Surgical Technician**, complete Section B-2 below.
- If the student is a **Nursing Student**, complete Section B-3 below.
- Do **not** complete both sections.

SECTION B-2: STUDENT MEDICAL ASSISTANT, DIALYSIS TECHNICIAN OR SURGICAL TECHNICIANS

☐ Student Medical Assistant ☐ Student Dialysis Technician ☐ Student Surgical Technician	
The student has completed the theory component of the program:	☐ Yes ☐ No

SECTION B-3: NURSING STUDENTS

Has completed a course in the fundamentals of nursing: Date of Course Completion: _____	☐ Yes ☐ No

SECTION B-3: NURSING STUDENTS (CONT)

MAIII Eligibility — Has successfully completed a course which includes medication administration which included all of the following: • Basic Clinical Skills • Basic Pharmacology • Principles of Medication Administration • Mathematics Competency	☐ Yes ☐ No

PROGRAM ADMINISTRATOR/DESIGNEE ATTESTATION

As the program administrator or designee, by signing this form, you are attesting that the information provided is true, correct, and complete to the best of your ability.

Program Administrator/Designee Name (printed)	Title
Program Administrator/Designee Signature	Date

[1]In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to North Dakota Century Code 43-50-02. The individual's social security number is used for identification purposes. Failure to provide the social security number will cause the application to not be processed.

Please submit completed form to:

North Dakota Board of Nursing
919 S 7th St., Suite 504
Bismarck, ND 58504-5881
Email: uap_maiii@ndbon.org
Fax: (701) 751-2221
Website: ndbon.org