

**DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF NURSING HOME ADMINISTRATORS
4052 BALD CYPRESS WAY, BIN #C-07
TALLAHASSEE, FLORIDA 32399-3257
(850) 245-4355**



ADMINISTRATOR-IN-TRAINING APPLICATION

September 2016

DEPARTMENT OF HEALTH
BOARD OF NURSING HOME ADMINISTRATORS
4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257
850/245-4355

**APPLICATION INSTRUCTIONS
FOR ADMINISTRATOR-IN-TRAINING**

*** PLEASE TYPE OR PRINT IN BLACK INK ***
PLEASE READ CAREFULLY

(Section 468.1695(2) and (4), Florida Statutes and Chapter 64B10-16, Florida Administrative Code)

THE FOLLOWING ITEMS MUST BE INCLUDED WITH YOUR APPLICATION:

You must COMPLETE your AIT program and have your last report approved BEFORE you submit your application for the exam.

APPLICANT'S QUESTIONS REGARDING APPLICATION STATUS: Within thirty (30) days after the board office receives your application and fee, we will send an acknowledgment letter informing you of any deficiencies and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date mailed, please contact this office. As a reminder to all applicants, Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

Florida Laws and Rules: A copy of Section 468, Part II, Florida Statutes and Rule Chapter 64B10, Florida Administrative Code are enclosed or you may download them at <http://floridasnursinghomeadmin.gov/resources/>. This information is also available over the internet via our web site. It is important to read this in order to determine your eligibility prior to applying, and to familiarize yourself with the statutes and board rules regarding your application for licensure as a nursing home administrator within the State of Florida.

Fee Schedule: A certified check or money order in the appropriate amount, made payable to the Department of Health, must be attached to your application. Please staple the certified check or money order to page 1 of the application on the upper left part of the form. Your application will not be processed without these fees. These fees are required by law and include the following:

1,000 Hour AIT Program:

Application Fee	\$ 250.00
Unlicensed Activity Fee	\$ 5.00
Total Fee	\$ 255.00

2,000 Hour AIT Program:

Application Fee	\$ 350.00
Unlicensed Activity Fee	\$ 5.00
Total Fee	\$ 355.00

Final Official Undergraduate Transcript: A final official transcript must be sent directly from the educational institution/college to this office. Transcripts submitted by the applicant or indicating "issued to student" are not acceptable; a copy of your diploma will not be accepted in lieu of an official transcript. Please note that it is your responsibility to follow-up with your educational institutions to ensure that they have received and complied with your requests. The board office will notify you as items are received.

AIT REVIEW AND STUDY TRAINING MANUALS: Please be advised the Board of Nursing Home Administrators is not requiring these manuals, but simply suggesting them for your use. To receive additional information on these manuals, go to the board's web site at <http://floridasnursinghomeadmin.gov/forms/nha-cib.pdf>

NURSING HOME ADMINISTRATORS

--- ADMINISTRATOR-IN-TRAINING (AIT) ---

APPLICATION CHECKLIST

- _____ 1. Application:
All questions answered on all pages and if question not applicable, mark with N/A.
All "Yes" answers must be accompanied by an explanation or documentation, as instructed. Public Records Disclosure regarding SSN
- _____ 2. Fees:
Please make certified check or money order payable to **DOH-Board of Nursing Home Administrators.**
- _____ 3. Qualified Preceptor Agreement
- _____ 4. Training:
_____ a. AIT 1,000 hours To qualify for a 1,000-hour Program, you must have

() Degree in Health Care Administration or
() Degree in Health Services Administration or
() Equivalent Degree (must have at least 60 semester hours in required courses, complete the course worksheet to determine if you qualify. Attach course description from school catalog if unsure.)

_____ b. AIT 2,000 hours A bachelor's degree in any field
- _____ 5. Official College Transcript
- _____ 6. AHCA Licensure and Life safety survey
- _____ 7. Facility Organizational Chart or complete form in application packet (Submit with application)

RETURN APPLICATION, FEES, AND SUPPORTING DOCUMENTS TO:

Florida Department of Health
Board of Nursing Home Administrators
Post Office Box 6330
Tallahassee, Florida 32314-6330

ADDITIONAL DOCUMENTATION, NOT ACCOMPANIED BY A FEE, SHOULD BE SENT TO:

Florida Department of Health
Board of Nursing Home Administrators
4052 Bald Cypress Way, BIN # C07
Tallahassee, Florida 32399-3257



CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Board of Nursing Home Administrators

Name:

Last **First** **Middle**

Social Security Number:

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257



ADMINISTRATOR-IN-TRAINING APPLICATION
(Client 801)

Mail To: Board of Nursing Home Administrators
Post Office Box 6330
Tallahassee, FL 32314-6330
<http://floridasnursinghomeadmin.gov/resources/>
(850) 245-4355

APPLICATION CATEGORY: (Must select one category – ONLY)

1,000 Hour AIT Program - \$255.00 (1009) 2,000 Hour AIT Program - \$355.00 (1009)

PROFILE DATA (Please print or type or application will be returned):

1. NAME: _____
(Last) (First) (Middle)

2. MAILING ADDRESS: _____
(Street and Number) (Apt. #) (City) (State) (Zip)

PRIMARY LOCATION: _____
(Street and Number) (Apt. #) (City) (State) (Zip)

3. TELEPHONE: () _____ () _____
Home: Area Code/Phone Number Work: Area Code/Phone Number

4. LICENSE NUMBER (If licensed another state): _____

5. E-MAIL ADDRESS: _____
(Email Notification: If you want to notified of the status of your application by email please check the “YES” box and write your email address on the line provided above. If you choose this form of notification you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the board office MQA.NursingHomeAdmin@flhealth.gov. Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.)

YES NO

6. US Citizen: Yes No

7. Date of Birth: _____

8. PERSONAL DATA - We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian African-American/Black Hispanic Asian Native American Other

SEX: Male Female

9. EDUCATIONAL DATA:

Degree Title: _____

4 Year _____ Master _____ Doctorate _____

Name of College or University: _____

Address: _____
(Street and Number) (City) (State) (Zip)

Date of Graduation: _____ Accredited by: _____

10. NURSING HOME AT WHICH A.I.T. PROGRAM WILL BE PROVIDED:

Name of Nursing Home: _____

Address: _____
(Street and Number) (City) (State) (Zip)

11. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If no, do not answer 11 a-d.)

Yes _____ No _____

11a. If "yes" to 11, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

Yes _____ No _____

11b. If "yes" to 11, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6) (a), Florida Statutes).

Yes _____ No _____

11c. If "yes" to 11, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

Yes _____ No _____

11d. If "yes" to 11, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).

Yes _____ No _____

12. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? (If no, do not answer 12a.)

Yes _____ No _____

12a. If "yes" to 12, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

Yes _____ No _____

13. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 13a.)

Yes _____ No _____

13a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

Yes _____ No _____

- 14. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 14a and 14b.)**
 Yes_____ No_____
- 14a. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?**
 Yes_____ No_____
- 14b. Did the termination occur at least 20 years prior to the date of this application?**
 Yes_____ No_____

15. APPLICANT SIGNATURE:

I state that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 456.072, 468.1745, and 468.1755, Florida Statutes. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instruments (local, state, federal or foreign) to release to the Department of Health, any information, files and/or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organization, individuals, and groups listed above, any information which is material to my application.

I understand that Florida law requires me, as an applicant for licensure, to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board of Nursing Home Administrators decision concerning my eligibility for licensure. (Section 456.013, Florida Statutes) Failure to do so may result in action by the Board including denial of licensure.

I further state that I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I understand that such action shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida in the profession for which I am applying.

I also state that I will comply with all requirements for licensure renewal in effect at the time of license renewal, including submission of appropriate renewal fees and completion of required continuing education credits.

As a reminder to all applicants, please understand that Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the Department.

 (Signature of Applicant)

 (Date)

Completed by Preceptor:

Name of Preceptor: _____

Mailing Address: _____
(Street and Number) (City) (State) (Zip)

E-mail Address: _____

Telephone Number: _____

License #: _____

AHCA Licensure Status Standard or Conditional:
(Attached a copy of the latest AHCA licensure and life safety Survey Report)

Number of Beds: _____ SNF: _____ ICF: _____

Administrator-in-Training Agreement:

This agreement entered into by the Administrator-Preceptor, _____,
the Administrator-in-Training, _____ and agree to the following conditions:

The Administrator-Preceptor shall provide supervision and guidance as designated for a
_____ period of time commencing on _____ as set out in
the guidelines of the Administrator-in-Training Program as provided in the Administrator-
Preceptor’s Training Course.

The Administrator-in-Training shall perform under the supervision of a duly qualified
Administrator-Preceptor and fulfill all terms and conditions required.

(Signature of Administrator-Preceptor)

(Date)

(Signature of Administrator-in-Training)

(Date)

FACILITY ORGANIZATIONAL CHART
(Preceptor Should Complete)

Name of Employee	Reports To
Activity Coordinator	
Assistant Administrator	
Business/Finance Director	
Director of Nursing	
Food Services Supervisor	
Housekeeping Supervisor	
Maintenance Supervisor	
Medical Director	

FACILITY ORGANIZATIONAL CHART
(Preceptor Should Complete)

Name of Employee	Reports To
Nursing Home Administrator	
Pharmacy Consultant	
Rehab Director	
Risk Manager	
Social Service Director	
Volunteer Coordinator	

Statement of Administrator-in-Training/Preceptor:

We hereby declare that to the best of our knowledge and belief, there are no misrepresentations or falsifications in the statements and answers we have given in this application or in any other documents or papers appended hereto.

(Signature of Administrator)

(Date)

(Signature of Administrator-in-Training)

(Date)