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

APPLICATION FOR NURSING HOME ADMINISTRATORS EXAMINATION & ENDORSEMENT/TEMPORARY

January, 2017

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

APPLICATION INSTRUCTIONS FOR ORIGINAL EXAMINATION & ENDORSEMENT/TEMPORARY

NOTE: Applications are accepted on a continuous basis, there are no deadlines.

1. **FLORIDA LAWS & RULES:** A copy of Section 468, Part II, Florida Statutes and Rule Chapter 64B10, Florida Administrative Code are available by downloading 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.

2. **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), F.S., provides that an incomplete application shall expire one year after initial filing with the department.

3. **EXAMINATION INFORMATION:** The Florida Nursing Home Administrators Examination consists of two parts; one being the NHA examination and the other being the Florida Laws and Rules examination. The NHA examination is developed and administered by the National Association of Board of Examiners of Nursing Home Administrators, ("NAB"). Upon board approval, you must submit your application through NAB's CDOM system at their website nabweb.org in order to be scheduled. The NAB CDOM will provide an email response informing you of your eligibility along with your authorization to test letter. You will be provided the toll-free number for use in scheduling your exam, a list of testing centers and appropriate online scheduling instructions. The Florida Laws and Rules examination is developed by the Florida Department of Health and administered by the contracted vendor. Both exams are given on a continued basis. For any information on examination scheduling and associated fees, please contact NAB.

4. **REVIEW AND STUDY COURSES:** The following organization offers a review or study course for the nursing home administrator licensure examination NAB. Please be advised the Board of Nursing Home Administrators is not recommending this course, but simply stating this as a courtesy to the sponsor. To receive additional information on dates and times the review is given, please contact the provider directly: Professional Health Care Education Systems, Inc., Post Office Box 291883, Tampa, Florida 33617, Attention: Inez Joseph, Ph.D., Phone (813) 982-1554.

5. **YES/NO QUESTIONS:** All questions with a "Yes or No" answer must be marked with either a "Yes" or "No" as no other response is acceptable. In questions which require a brief explanation or description to "Yes" answers, your responses must be sufficiently detailed to ascertain the dates, institution/organization names, and a brief synopsis of the reasons (i.e., the final charges or substantiated allegations only) the institution/organization took the disciplinary action (i.e., probation, limitation, suspension, revocation, voluntary relinquishment in lieu of disciplinary action, or any other adverse action). HOWEVER, IF A QUESTION CONTAINED IN THIS SURVEY IS NOT APPLICABLE ANSWER "N/A" IN THE NO COLUMN. **Documentation of final disposition to "yes" answers is required.**

6. **ADDITIONAL SPACE NOTE:** Should any of the sections in the application fail to provide sufficient space for the requested information, use an additional page or the reverse side of the application page on which the question is located. Always number the additional information with the corresponding number in the application.

7. **FEDERAL PRIVACY ACT:** Under the Federal Privacy Act, disclosure of social security numbers is voluntary unless specifically required by federal statute. In this instance, social security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654: and sections 456.013, 409.257(7) and 409.259(8), F. S. Social security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social security numbers must also be recorded on all professional and occupational license applications and will be used for license verification pursuant to, unless exempt as outlined in the

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

Note: If you do not fill in your social security number, your application may be delayed. You must possess a social security number prior to receiving a license.

SUPPORTING DOCUMENTS - THE FOLLOWING ITEMS MUST BE INCLUDED WITH YOUR APPLICATION:

8. **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:

Examination:

Examination Fee	$250.00
Initial Licensure Fee	$500.00
Laws and Rules Fee	$190.00
Unlicensed Activity Fee	$ 5.00
Total Fee	**$945.00**

Endorsement:

Initial Licensure Fee	$500.00
Laws and Rules Fee	$190.00
Unlicensed Activity Fee	$ 5.00
Total Fee	**$695.00**

Temporary License:

Application Fee	$325.00
Licensure Fee	$150.00
Total Fee	**$475.00**

9. **Final Official Transcripts:** 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.

10. **Official Licensure Verification:** The licensure verification form included with this application package must be sent to each state where you currently have or have held a license to practice. These forms must be sent directly from each state licensing agency to this office. Please note that it is your responsibility to follow-up with licensing agencies to ensure that they have received and complied with your requests. **A copy of your license will not be accepted in lieu of official verification from the licensing agency.**

11. **Verification of Employment Forms:** It is the responsibility of the applicant applying for licensure by endorsement to provide documentation attesting 2 years of experience as an administrator of a skilled nursing home within the last five years, provide a job description and organization chart.

12. **Endorsement:** Persons licensed in other states who are not eligible for endorsement due to not having worked two (2) of the last five (5) years as a nursing home administrator, must meet the initial eligibility requirements for examination in Section 68.1695(2), Florida Statutes. You may submit an Examination application and you MUST include an official licensure verification for each State to which you are licensed.

13. **Temporary Licensure (Only with Endorsement Applicants):** Only those applicants who apply for and meet all requirements for licensure by endorsement are eligible to apply for the temporary license. A temporary license terminates upon the holder's receipt of notification of the examination results or if you cease to function as administrator of the above named facility. A t emporary license cannot be renewed, nor can it be transferred to another individual or facility. The temporary application and the additional $250 fee must accompany the endorsement application.

14. Eligibility for National Examination:

a. One year Practical Experience: If you are applying based on a degree AND 1 year of management experience in the areas of executive duties and skills, including the staffing, budgeting, and directing of resident care, dietary, and bookkeeping departments within a skilled nursing facility, hospital, hospice, assisted living facility with a minimum of 60 licensed beds, or geriatric residential treatment program and, if such experience is not a skilled nursing facility, has fulfilled the requirements of a 1,000 hour nursing home administrator-in-training program prescribed by the board. The proof of experience must include a statement from your employer stating the beginning and ending dates that you held in the position, named facilities, job descriptions and organization charts.

b. Internship/AIT Training: Verification must include a statement directly from the college/university program director certifying successful completion of all internship training and verification of the number of clock hours, name of nursing home and preceptor. If more than one nursing home was utilized, verification must be furnished for each nursing home. The applicant shall submit the Certificate of Internship/A.I.T. Training Preceptor's Statement.

15. Request for an Application for Special Testing Accommodations: You must complete this form and mail it to the address shown on the bottom of the application. This form does not constitute an application for special testing accommodations. The Department will mail you an application to be completed and returned back to the Bureau of Operations, Testing Services.

YOUR APPLICATION IS NOT CONSIDERED COMPLETE UNTIL ALL SUPPORTING DOCUMENTS AND FEES HAVE BEEN RECEIVED BY THIS OFFICE.

--- EXAMINATION ---

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 and documentation, as instructed.
Public Records Disclosure SSN

_____ 2. Fees:
Please make certified check or money order payable to **DOH–Board of Nursing Home Administrators**

_____3. Training: select ONE (1)
_____ a. Preceptor Statement (AIT)
_____ b. Preceptor Statement (College Internship)
_____ c. One-year Management Experience

_____4. Experience Qualifications:
_____ a. Exam less than TWO (2) years' experience as a NHA
_____ b. Job Description
_____ c. Organizational Chart
d. Out of State(s) Licensure Questionnaire – **(must include raw or scale score of 113 or above)**

_____5. Official College Transcript

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

--- ENDORSEMENT ---

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 and written documentation, as instructed.
Public Records Disclosure SSN

_____ 2. Fees:
Please make certified check or money order payable to **DOH–Board of Nursing Home Administrators**

_____ 3. Qualifications:
_____ a. Proof of TWO (2) years' experience as a NHA
_____ b. Job Description
_____ c. Organizational Chart
_____ d. Out of State(s) Licensure Questionnaire – **(must include raw or scale score of 113 or above)**

_____ 4. Official College Transcript

_____ 5. Temporary Licensure:
Complete the Temporary Licensure Application and fee with the Endorsement 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:

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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

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.

Name: _____
Last **First** **Middle**

Social Security Number: _____

APPLICANT HISTORY: (If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)

1. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [ ] YES [ ] NO

2. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? [ ] YES [ ] NO

3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice within the past five years? [ ] YES [ ] NO

4. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice? [ ] YES [ ] NO

5. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? [ ] YES [ ] NO

6. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice within the last five years? [ ] YES [ ] NO

APPLICATION FOR NURSING HOME ADMINISTRATORS
EXAMINATION & ENDORSEMENT/TEMPORARY
(Client 801)

READ/DOWNLOAD APPLICATION INSTRUCTIONS FOR IMPORTANT INFORMATION

APPLICATION CATEGORY/APPLICABLE FEES: (TYPE OR PRINT LEGIBLY IN BLACK INK)

[ ] EXAMINATION (1010)	**TOTAL: $ 945.00**
[ ] ENDORSEMENT (1012)	**TOTAL: $ 695.00**
[ ] TEMPORARY LICENSE (additional $475.00) **(if applicable-ONLY with Endorsement Application)**	**TOTAL: $1,170.00**

APPLICANT PROFILE:
PROFILE DATA: (PLEASE PRINT OR TYPE IN BLACK INK)

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

Have you changed your name through marriage or through action of a court, or have you been known by any other name? [ ] YES [ ] NO

If YES, list provide: _____
(Last) (First) (Middle)

2. ADDRESS:

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

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

c. **TELEPHONE:** (____)_____ (____)_____
Primary: Area Code/Phone Number **Business: Area Code/Phone Number**

d. **EMAIL 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

3. PERSONAL DATA:

a. Date of Birth: _____
(Month/Day/Year)

b. 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: [ ] White [ ] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other
SEX: [ ] Male [ ] Female

c. Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disasters? [ ] YES [ ] NO

NAME: _____

EMPLOYMENT:

4. PRACTICE/EMPLOYMENT: List in chronological order from date of graduation to present date, all practice employment, non-employment and/or any unaccounted period of time.

(Name of Business)	(Full Mailing Address)	(Type of Employment)	(From: MM/DD/YYYY To: MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(Type of Employment)	(From: MM/DD/YYYY To: MM/DD/YYYY)
(Name of Business)	(Full Mailing Address)	(Type of Employment)	(From: MM/DD/YYYY To: MM/DD/YYYY)

EDUCATION and TRAINING:

5. UNDERGRADUATE/GRADUATE/PROFESSIONAL EDUCATION: Please provide undergraduate, graduate, and professional education, listing all schools, colleges and universities attended, whether completed or not, in chronological order.

(School Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)
(School Name)	(City/State)	(From: MM/DD/YYYY – To: MM/DD/YYYY)	(Graduation Date)	(Degree Awarded)

6. POSTGRADUATE TRAINING: List in chronological order from date of graduation/completion of all professional/postgraduate training (Internship/Residency/Fellowship).

(Program Name)	(City/State/Country)	(Program Type)	(From: MM/DD/YYYY–To: MM/DD/YYYY)	(# of hours completed)
(Program Name)	(City/State/Country)	(Program Type)	(From: MM/DD/YYYY–To: MM/DD/YYYY)	(# of hours completed)

7. NATIONAL CERTIFICATION EXAMINATION:

Did you successfully pass a National Certification Examination in the area of applying for licensure: [ ] YES [ ] NO

(If **YES**, please provide the following:)

(Name of National Certification Examination)	(Examination Date)
(Name of National Certification Examination)	(Examination Date)

8. LICENSURE INFORMATION: Do you hold or have you ever held a license or certificate or registration to practice Nursing home administration in this state or any other state? [ ] YES [ ] NO

License Number	State/Country	Original Date Issued	Expiration Date
License Number	State/Country	Original Date Issued	Expiration Date
License Number	State/Country	Original Date Issued	Expiration Date

PLEASE NOTE: Verification of each license must be received directly from the licensing authority, regardless of status of license.

NAME: _____

ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

PROCEEDINGS and/or ACTIONS

9. APPLICANT HISTORY:

a. Have you had any application for a professional license, or any application to practice, denied by any state board or other governmental agency of any state or country? [ ] YES [ ] NO

b. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Nursing Home Administrators practice act, unprofessional or unethical conduct? [ ] YES [ ] NO

If **YES**, please complete the following:

(Name of Agency)	(City/State)	(Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)
(Name of Agency)	(City/State)	(Date: MM/DD/YYYY)	(Final Action)	(Under Appeal? Y/N)

10. LICENSURE ACTIONS:

a. Have you ever had a license disciplined for sexual misconduct or committed any act in any other state that would constitute sexual misconduct? [ ] YES [ ] NO

b. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action taken in any state or other jurisdiction? [ ] YES [ ] NO

c. Have you been refused a license to practice, or the renewal thereof in any state? [ ] YES [ ] NO

11. CRIMINAL INFORMATION:

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? [ ] YES [ ] NO

If **YES**, you must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.

(Offense)	(Date: MM/DD/YYYY)	(Jurisdiction)	(Final Disposition)	(Under Appeal? Y/N)
(Offense)	(Date: MM/DD/YYYY)	(Jurisdiction)	(Final Disposition)	(Under Appeal? Y/N)

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

12. Have you been convicted of, or entered a plea of guilty or nolo contendere, 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 felon offense(s) in another state or jurisdiction? **(If you responded NO, skip to 13)** [ ] YES [ ] NO

NAME: _____

a. If "yes" to 13, for 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

b. If "yes" to 13, for 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

c. If "yes" to 13, for 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

a. If "yes" to 13, 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

13. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to 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)? [ ] YES [ ] NO

a. If "yes" to 13, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? [ ] YES [ ] NO

14. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 14a.)** [ ] YES [ ] NO

a. 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

15. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **(If "No", do not answer 15a or 15b.)** [ ] YES [ ] NO

a. Have you been in good standing with a state Medicaid program for the most recent five years? [ ] YES [ ] NO

b. Did the termination occur at least 20 years before to the date of this application? [ ] YES [ ] NO

16. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? [ ] YES [ ] NO

I, the undersigned, state that I am the person referred to in this application for licensure in the State of Florida.

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.

APPLICANT SIGNATURE: _____ DATE: _____

LICENSE VERIFICATION

INSTRUCTIONS TO THE APPLICANT:
1. Complete the information in Part I only.

2. This form must be returned by the state Board or agency which issued your license.

PART I: TO BE COMPLETED BY APPLICANT: (PRINT or TYPE)

Name**:** _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip/Postal Code)

DOB: ____/____/_____ License No.: _____ Title of License: _____

PART II: TO BE COMPLETED BY THE STATE BOARD OFFICE: (PRINT or TYPE)

The individual listed above has applied for licensure in Florida as a Nursing Home Administrator. Before further consideration is given to this application, we require the information requested on this form. The Board may submit your standard verification form in lieu of completing this form, as long as you indicate whether or not discipline has been taken against the license, and affix the Board seal. **Please return the requested information to: Florida Board of Nursing Home Administrators, 4052 Bald Cypress Way, Bin #C07, Tallahassee, Florida 32399-3257**

Licensee Name: _____
(Last) (First) (Middle)

State: _____ Title of License: _____ License No.: _____ Original Issue Date:____/____/_____

THIS LICENSE IS CURRENTLY:
[ ] Active [ ] Inactive [ ] Temporary [ ] Other (Explain)

THIS LICENSE WAS OBTAINED BY:
[ ] Examination [ ] Grandfathering [ ] Reciprocity/Endorsement

ACTION TAKEN AGAINST LICENSE:
[ ] No Disciplinary Action Taken [ ] Disciplinary Action Taken*****

Please Affix Board Seal

_____ _____
Print Name (Completing form) Title

_____
Signature

If disciplinary action has been taken against this licensee, please provide copies of documentation regarding any disciplinary actions directly to the Florida Board of Nursing Home Administrators.

Did this applicant take a written examination for licensure? [ ] Yes [ ] No [ ] NAB [ ] PES [ ] Other

a. Provide exams and dates _____ Exam Series # _____
b. Total Raw Score _____ Scaled Score

CANDIDATE REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities Act, please **submit to Professional Examination Service**, this **completed form and attach supporting documentation of your disability and need for accommodators** so your accommodations for testing can be processed efficiently. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

Applicant Information:

Last Name First Name Middle Name

Address (line 1)

Address (line 2)

City State Zip Code

Jurisdiction in which you have applied for licensure

Special Accommodations - I request special accommodations for the administration of the (Please check each examination that applies to you.)

- ❑ Nursing Home Administrators Licensing Exam (NHA)
- ❑ State-Based Laws & Regulations Exam (NSBL)

Please provide (check all that apply):

_____ Accessible testing site

_____ Special seating

_____ Large print test (specify point size) _____

_____ Reader

_____ Circle answers in test booklet

_____ Extended testing time (time and a half)

_____ Separate testing area

_____ Other special accommodations (please specify)

_____

_____

_____

Send original documents to:
Professional Examination Service
Attention: NAB Program Director (644)
475 Riverside Drive, 6th Floor
New York, NY 10115-0089

Send copies to:
State Board/Agency in which you are making application for licensure

THE FOLLOWING PAGES NEED TO BE INCLUDED WITH THE

EXAMINATION APPLICATION

CERTIFICATE OF INTERNSHIP/A.I.T. TRAINING PRECEPTOR'S STATEMENT

TO: Florida Board of Nursing Home Administrators

FROM: _____
(Applicant/Trainee Name)

PLEASE PRINT or TYPE the following information:

I state that under my preceptorship, the administrator in training received training in all aspects of nursing home management and operation, including training in the domains of practice (Chapter 64B10-16, Florida Administrative Code), with required time in each domain as indicated.

Administrator Name: _____ License #: _____

Name of Nursing Home: _____

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

Please select: [ ] Internship or [ ] A.I.T.

Dates: _____ to _____ Weeks/Hours: _____
Month/Date/Year Month/Date/Year

During this training period, the administrator in training has not performed in a dual capacity and was singularly involved in the Internship/A.I.T. Program.

Internship: _____
Name of Approved College or University

A.I.T.: _____
Names of Florida Board Monitor

Please list actual percent of total hours listed above: (Total will equal 100%) Actual %

1. **Resident Care:** Nursing; Food; Social & Recreational Services; Volunteers; Pharmacy Rehabilitation; Physicians' Services and Medical Records total time devoted to this area should be 20% minimum. _____
2. **Personnel:** Recruitment; Interviews; Employee Selection; Training; Personnel Policies; Health and Safety should be 15% minimum. _____
3. **Finance:** Accounting; Budgeting; Financial Planning & Asset Management should be 15% minimum. _____
4. **Marketing:** Public Relations Activities & Marketing Programs should be 5% minimum. _____
5. **Physical Resource Management:** Safety Procedures; Fire & Disaster Planning; Building and Environment Maintenance should be 10% minimum. _____
6. **Laws, Regulatory Codes and Governing Boards:** Federal, State and Local laws; Rules and Regulations should be 10% minimum. _____

Evaluation of Internship/A.I.T.: [ ] Superior, [ ] Satisfactory, [ ] Unsatisfactory

Signature of Preceptor: _____ Date: _____

ELIGIBILITY FOR EXAMINATION
(Administrator In Training)
(Section 468.1695(2)(b)2., F.S.)

Name**:** _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip/Postal Code)

Telephone Number: _____

Please PRINT or TYPE:

Verification of Education: (A final official transcript must be sent directly from the educational institution/college to this office.)

[ ] Baccalaureate: (Health Care Administration)
[ ] Baccalaureate (other)

Degree Title: _____

Name of College or University: _____

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

Date of Graduation: _____ Accredited by: _____

Administrator In Training: (Board approved as prescribed by Chapter 64B10-16, Florida Administrative Code.)

Please select:
[ ] **1,000 Hours or** [ ] **2,000 Hours**

Board Monitor's Name: _____ Number of Hours: _____

Date Completed: _____

Name of Nursing Home: _____ Number of Beds: _____

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

Preceptor's Name: _____ License Number: _____

ELIGIBILITY FOR EXAMINATION
(Internship)
(Section 468.1695(2)(a)2., F.S.

Name**:** _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip/Postal Code)

Telephone Number: _____

Please PRINT or TYPE:

Verification of Education: (A final official transcript must be sent directly from the educational institution/college to this office.)

[ ] Baccalaureate: (Health Care Administration)
[ ] Baccalaureate (other)

Degree Title: _____

Name of College or University: _____

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

Date of Graduation: _____ Accredited by: _____

Internship Program: (If more than one nursing home was needed for completion of program, attach additional page(s) with the information provided below for each Nursing Home. Attach verification from preceptor documenting completion of Internship/A.I.T. Program and statement from the College or University as to the number of credit hours for the internship program.)

Name of College or University: _____

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

Number of Hours: _____ Date Complete: _____

Name of Nursing Home: _____ Number of Beds: _____

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

Preceptor's Name: _____ License Number: _____

(OR)

ELIGIBILITY FOR EXAMINATION
(One Year Practical Experience)
(Section 468.1695(2)(b)2.b., F.S.)

Name**:** _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip/Postal Code)

Telephone Number: _____

Please PRINT or TYPE:

Verification of Education: (A final official transcript must be sent directly from the educational institution/college to this office.)

[ ] Baccalaureate: (Health Care Administration)
[ ] Baccalaureate (other)

Degree Title: _____

Name of College or University: _____

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

Date of Graduation: _____ Accredited by: _____

One Year Management Experience: (Provide organization chart, job description, and statement from employer verifying your responsibilities and experience with specific dates to document 1 year of experience.)

SNF: _____

Title of Position: _____

Name of Nursing Home: _____ Number of Beds: _____

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

Telephone Number: _____ Dates: _____ to _____
Month/Date/Year Month/Date/Year

Supervisor's Name: _____ Title: _____

THE FOLLOWING PAGES NEED TO BE INCLUDED WITH THE

ENDORSEMENT/TEMPORARY APPLICATION

APPLICATION OF TEMPORARY LICENSURE

(Client 801)

Fee for Temporary License - $475.00 (Must be accompanied by an endorsement application and meet all requirements)

To be Completed by Applicant:

Name**:** _____
(Last) (First) (Middle)

Name of Nursing Home: _____

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

Telephone Number: _____ Effective Date: _____
Month/Date/Year

I request a temporary license to be issued based on my application for licensure by endorsement from the State of, where I currently hold an active license. I understand that the holder of a temporary license is required to take and pass the laws and rules examination within 90 days of the issuance of this temporary license. I understand that I am subject to the Laws of the State of Florida and rules and regulation of the Board of Nursing Home Administrators governing the practice of nursing home administration in Florida under whose authority a temporary license may be issued. A temporary license terminates upon the holder's receipt of notification of the examination results or if you cease to function as administrator of the above named facility. Failure to pass the examination shall automatically void this license and disqualify you for any subsequent temporary license. A temporary license cannot be renewed, nor can it be transferred to another individual or facility.

Signature of Applicant: _____ Date: _____

To be Completed by Employer/Owner:

Name**:** _____
(Last) (First) (Middle)

Title of Employer/Owner: _____

Name of Nursing Home: _____

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

Name Past Administrator: _____ License #: _____

I understand that the above applicant will be granted only a temporary license until such time as he/she has met the Florida requirements for permanent license. I understand that these requirements must be met when the applicant takes the next scheduled examination in Florida. In the event this applicant resigns from this position or is terminated prior to licensure, I agree to notify the Board of Nursing Home Administrators office within 24 hours.

Signature of Employer/Owner: _____ Date: _____

ELIGIBILITY FOR ENDORSEMENT
VERIFICATION OF EDUCATION/EMPLOYMENT

Name**:** _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip/Postal Code)

Telephone Number: _____

Please PRINT or TYPE:

Verification of Education: (A final official transcript must be sent directly from the educational institution/college to this office.)

[ ] Baccalaureate: (Health Care Administration)
[ ] Baccalaureate (other)

Degree Title: _____

Name of College or University: _____

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

Date of Graduation: _____ Accredited by: _____

Verification of Employment: (2 years of management experience within the last 5 years. Provide organization chart, job description, and statement from employer verifying your responsibilities and experience with specific dates to document 2 years of experience.)

Title of Position: _____

Name of Nursing Home: _____ Number of Beds: _____

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

Telephone Number: _____ Dates: _____ to _____
Month/Date/Year Month/Date/Year

Supervisor's Name: _____ Title: _____