Administrator-In-Training Application

Board *of* Nursing Home Administrators
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: floridasnursinghomeadmin.gov
Email: info@floridasnursinghomeadmin.gov
Phone: (850) 245-4355
Fax: (850) 922-8876

DH-MQA NHA003, 6/2020, Rule 64B10-16.001, F.A.C.

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at http://www.flhealthsource.gov/valor

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Do Not Write in this Space
For Revenue Receipting Only

1,000-hour (6 month) **Administrator-In-Training (A.I.T.) Program** (1009) **$255.00**

2,000-hour (1 year) **A.I.T. Program** (1009) **$355.00**

Total fee includes the following:

	1,000-hour	2,000-hour
Application Fee	$250.00	$350.00
Unlicensed Activity Fee	$5.00	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. The application fee is non-refundable.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

_____ _____ _____
Street Apt. No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with Section 60-3, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38295 and 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.

Gender: Male Female

Race: Native Hawaiian or Pacific Islander; American Indian or Alaska Native; Two or More Races; Hispanic or Latino; Black or African American; White; Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email 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.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * 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, § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure 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 identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice in any health-related field(s)? Yes No

C. List all health-related licenses (active, inactive or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

4. EDUCATION HISTORY

A. List undergraduate, graduate, and professional education, listing all schools/colleges/universities attended, whether completed or not, in chronological order.

School Name/Address	Accredited By	Graduation Date (MM/DD/YYYY)	Degree Awarded

Applicants applying under the A.I.T. 1,000 hours must meet one of the following criteria to qualify: (1) a degree in Health Care Administration (2) a degree in Health Services Administration or (3) an equivalent degree (the degree must have at least 60 semester hours in required courses. Complete the course worksheet to determine if you qualify. You can submit a course description from the school catalog if you are unsure whether it meets requirements.

Applicants applying under the A.I.T. 2,000 hours must have a bachelor's degree in any field.

All applicants must have an official transcript forwarded directly to the board office from your educational program. Diplomas and student copies are not acceptable. Transcripts should be sent to:

Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

B. Nursing Home at which Administrator-In-Training Program will be provided:

Name of Nursing Home: _____

Address: _____
Street and Number City State Zip

All applicants must submit:

A "Life Safety Survey," which is a facility inspection that is supplied by the facility.

The Facility Organization Chart form that follows the application.

Name: _____

This information is exempt from public records disclosure.

5. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

6. DISCIPLINE HISTORY

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 in any state or other jurisdiction? Yes No

C. Have you ever been refused a license to practice, or the renewal thereof in any state? Yes No

If you responded "Yes" to any of the questions in this section, complete the following:

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

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

7. CRIMINAL HISTORY

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? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. Yes No

If you responded "Yes," complete the following:

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

If you responded "Yes" in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

Final Dispositions and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

   If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, 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

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? Yes No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation?
      Yes No

   d. If "Yes" to 1, 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," provide supporting documentation)?
      Yes No

2. 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 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

   If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, 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

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.?
   Yes No

   If you responded "No" to the question above, skip to question 4.

   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

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If you responded "No" to the question above, skip to question 5.

a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No

b. Did termination occur at least 20 years before the date of this application? Yes No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the following questions, provide:

A written self-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 listed on the first page of the application.

Supporting documentation including court dispositions or agency orders where applicable.

Documents in sections 5, 6, 7, and 8 must be sent to the board office at:

Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

9. APPLICANT SIGNATURE

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

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067 and 775.083, F.S.

I understand that Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed. Failure to do so may result in action by the board including denial of licensure.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant's Signature _____ Date _____

You may print this application and sign it or sign digitally. MM/DD/YYYY

Name: _____

Board *of* Nursing Home Administrators
Preceptor Agreement

This form must be completed by your Preceptor

Name of Preceptor: _____

Facility Address: _____
Street and Number City State ZIP

Email Address: _____

Telephone Number: _____

License Number: _____

AHCA Licensure Status: Standard Conditional

(Attach a copy of the latest AHCA Life Safety Survey Report and revisit report with letter stating all deficiencies are complete)

Number of Beds: _____ SNF: _____ ICF: _____

Administrator-In-Training Agreement

This agreement entered into by the Administrator-Preceptor, _____,

the Administrator-In-Training, _____ agree to the following conditions:

The Administrator-Preceptor shall provide supervision and guidance as designated for a:

1,000-hour (6-month) program 2,000-hour (1-year) program

commencing on _____ as set out in the guidelines of the Administrator-In-Training Program
(MM/DD/YYYY)
as provided by 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.

Administrator-Preceptor Signature: _____ Date: _____
MM/DD/YYYY

Administrator-In-Training Signature: _____ Date: _____
MM/DD/YYYY

Name: _____

Board *of* Nursing Home Administrators
Facility Organization Chart

This form must be completed by Preceptor

Name of Employee	Reports To
Activity Coordinator	
Assisted Administrator	
Business/Finance Director	
Director of Nursing	
Food Services Supervisor	
Housekeeping Supervisor	
Maintenance Supervisor	
Medical Director	
Nursing Home Administrator	
Pharmacy Consultant	
Rehab Director	
Risk Manager	
Social Services 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 paper appended hereto.

Administrator-Preceptor Signature:_____ Date: _____
MM/DD/YYYY

Administrator-In-Training Signature: _____ Date: _____
MM/DD/YYYY