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

APPLICATION FOR NURSING HOME ADMINISTRATORS RE-EXAMINATION

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

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. Please download the Candidate Information Booklet (CIB) for this examination from the Testing Services website at http://www.floridahealth.gov/licensing-and-regulation/_documents/nha-cib.pdf. Both exams are given on a continuing basis. Please allow 30 days after you receive the on-site results for the Department to process your official grade results. 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 NAB nursing home administrator licensure examination. 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", "No", or "N/A". In questions which require a brief explanation or description to "Yes" answers, your responses must be sufficiently detailed to ascertain the **relevant 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).

6. RETAKE APPLICANTS: Applicants who are retaking either examination should log on to the NAB website for the National Examination and/or Prometric for the Florida Laws and Rules Examination. You **MUST** submit a new complete application and reexamination fees. Retake applicants are **NOT** required to resubmit transcripts or any other documentation previously provided; however, licensure verifications must be resubmitted. You are allowed to retake the examination four times within a 12-month period from the date of your initial application. You must wait 30 days after failure of each examination to retake.

7. 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.

8. 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 have not been issued a social security number by the Federal Government at the time of application because you are not a citizen or resident of this country, the department may process the application using a unique personal identification number. If you are otherwise eligible for licensure, the board, or the department when there is no board, may issue a temporary license, which shall expire 30 days after issuance unless a social security number is obtained and submitted in writing to the department. Upon receipt of the social security number, the department shall issue a new license, which shall expire at the end of the current biennium.

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

9. 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:

Re-examination:

NAB and LAWS & RULES (Both)	
Examination Fee	$ 250.00
Laws and Rules Fee	$ 190.00
National Examination Only	$ 0
Total Fee:	**$ 440.00**

LAWS & RULES (Only)	
Examination Fee	$ 250.00
Laws and Rules Fee*	$ 190.00
Total Fee:	**$ 440.00**

*See Rule 64B-1.016 **Fees: Examination and Post-Examination Review –** The fees cover administrative costs, actual per-applicant costs, and costs incurred to develop, purchase, validate, administer, and defend department developed, administered, or managed examinations.

10. Official Licensure Verification: The licensure verification forms included with this application package must be sent to each state or other licensing authority where you currently hold or have held a license to practice, regardless of the status of the license. 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. The board office will notify you as items are received. **A copy of your license will not be accepted in lieu of official verification from the licensing agency.**

11. 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.

NOTE: Language interpretation services are available to applicants for licensure who have limited-English proficiency or a hearing/speech impairment. If you need an interpreter in order to talk with your application processor, please indicate that information when you call the board office. An interpreter and the processor will call you back shortly in order to handle your call.

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), and (12), 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 [ ] N/A

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 [ ] N/A

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 [ ] N/A

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 [ ] N/A

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 [ ] N/A

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 [ ] N/A

APPLICATION FOR NURSING HOME ADMINISTRATORS
RE-EXAMINATION (Client 801-1011)

READ/DOWNLOAD APPLICATION INSTRUCTIONS FOR IMPORTANT INFORMATION

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

RE-EXAMINATION: [ ] **NAB** **TOTAL: $ 0**

[ ] **Florida Laws & Rules** **TOTAL: $440.00**

[ ] **BOTH (NAB & Florida Laws & Rules)** **TOTAL: $440.00**

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 [ ] N/A

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 info@FloridasNursingHomeAdmin.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 [ ] N/A

4. **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 [ ] N/A

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

5. APPLICANT HISTORY:

a. Have you had <u>any</u> 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 [ ] N/A

b. Have you ever been notified to appear before <u>any</u> licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Clinical Laboratory practice act, unprofessional or unethical conduct? [ ] YES [ ] NO [ ] N/A

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)

6. 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 [ ] N/A

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 [ ] N/A

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

7. 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 [ ] N/A

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.

8. 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 9)** [ ] YES [ ] NO [ ] N/A

a. If "yes" to 8, 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 [ ] N/A

NAME: ____

b. If "yes" to 8, 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 [ ] N/A

c. If "yes" to 8, 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 [ ] N/A

d. If "yes" to 8, 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 [ ] N/A

9. 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 [ ] N/A

a. If "yes" to 9, 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 [ ] N/A

10. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 10a.)** [ ] YES [ ] NO [ ] N/A

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 [ ] N/A

11. 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 11a or 11b.)** [ ] YES [ ] NO [ ] N/A

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

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

12. 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 [ ] N/A

13. If "yes" to any of the questions 8 through 12 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health?
(If "yes", please provide official documentation verifying your enrollment status.) [ ] YES [ ] NO [ ] N/A

NAME: ____

14. APPLICANT SIGNATURE:

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, 775.082, 775.083, and 775.084, 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: ______________________________

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 the appropriate documentation as indicated in the Candidate Handbook** 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

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 certified 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 __________