

Master's or Reciprocity Application Instructions

Allow the Program 30 days to process your application. You will be notified in writing if the application is incomplete.

Print the entire application and required forms. Use the checklist below to ensure you have completed and included all the required forms prior to submitting your application.

To apply to the Nursing Home Administrator Program through Reciprocity, you must:

- Complete the Master's or Reciprocity Application and submit all required documentation.
- Must be at least 18 years of age, be a citizen of the United States or a legal resident and have a reputable and responsible character.
- Submit a copy of both the driver's license **and** social security card (*Do not send originals*).
- Have a Baccalaureate degree or higher.
- Be cleared through a background check for convictions of any crimes.
- Pay the appropriate fees established by the Program.
- Have a **current** nursing home administrator license free of disciplinary actions.
- Submit a license-verification filled out by the state of licensure.
- National Examination score must be a 113 or higher.

To apply to the Nursing Home Administrator Program with a Master's Degree, you must:

- Complete the Master's or Reciprocity Application
- Must be at least 18 years of age, be a citizen of the United States or a legal resident and have a reputable and responsible character.
- Submit a copy of both the driver's license and social security card (*Do not send originals*).
- Have a Master's degree in a health related field.
- Submit proof that a 480 hour internship was completed during the Master's program.
- Be cleared through a background check for convictions of any crimes.
- Pay the appropriate fees established by the Program.

Master's or Reciprocity Application Checklist

APPLICATION FEE \$611: Submit a money order or cashier's check in the amount of \$611 made payable to the Nursing Home Administrator Program. The application fee is non-refundable.

APPLICATION: The application must be completed in its entirety with all questions answered. Failure to do so will result in an incomplete application and a deficiency letter will be mailed to you. Failure to correct the deficiencies will result in your application being deemed abandoned. You must complete, sign, and date the application. All signatures must be original.

*Applying through Reciprocity

*Applying using a Master's Degree

PHOTO (2x2) & IDENTIFICATION: A passport style photo must be taken and attached to the first page of the application. A copy of a government issued Identification Card, Passport, Drivers License must also accompany the photo for verification purposes.

OFFICIAL TRANSCRIPT: You must submit an official (unopened) transcript that evidences the completion of required college or university courses, degrees, or both. Minimum of a Bachelor degree must be earned. An applicant who is a member of a recognized church or religious denomination whose teachings historically prohibit the acquisition of the formal education that would otherwise be required to qualify the applicant for the AIT Program may request a written waiver of the education requirements from the department. (Per Health & Safety Code 1416.55(f))

Please note: Foreign transcripts must be evaluated and deemed equivalent by a recognized credential evaluation organization.

FOR MASTER'S DEGREE APPLICANTS: You must submit an official transcript showing a Master's degree was earned in a health related field. You must also submit a letter from the school or facility showing that an internship of at least 480 hours was completed during the Master's program.

LICENSE VERIFICATION: Have the licensing board of the state in which you are currently licensed fill out page 5 of the application. Duplication of this page is permitted.

DOCUMENT VALIDATION: Please provide one of the following for Citizenship/Legal Resident verification.

- US Birth Certificate (certified copy from state or local vital statistics office)
- US Certificate of Birth Abroad or Report of Birth Abroad
- Federal Proof of Indian Blood Degree
- USCIS American Indian Card
- Birth Certificate or passport issued from a US Territory
- US Passport
- US Military Identification Cards (Active or reserve duty, dependent of a military member, retired member, discharged from service, medical/religious personnel)
- Common Access Card (only if designated as Active military or Active Reserve or Active Selected Reserve)
- Certificate of Naturalization or Citizenship
- USCIS US Citizen ID Card
- Permanent Resident Card

Master's or Reciprocity Application For Nursing Home Administrator Examination

Return this completed form, with a cashier's check or Money Order for the application fee of \$70, LiveScan processing fee \$51, State Exam fee \$210 and initial license fee \$280 (Total \$611)-Payable to NHAP. Please send to the following address:

**Nursing Home Administrator Program
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416**

In this space, attach a recent photo (within previous 90 days), sized approximately 2" by 2", clearly picturing the applicant's face.

(FOR IDENTIFICATION PURPOSES ONLY)

PRINT OR TYPE

APPLICANT'S LEGAL NAME <i>(Last)</i>	<i>(First)</i>	<i>(M.I.)</i>	SOCIAL SECURITY NUMBER *
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CURRENT ADDRESS *(If PO Box, Must provide street address as well)*

PERMANENT MAILING ADDRESS INCLUDING POSTAL CODE *(if different from current address listed above)*

BUSINESS MAILING ADDRESS

IDENTIFY PREFERRED PUBLIC RECORD ADDRESS	DAYTIME PHONE	EVENING PHONE
Current Permanent Business		
DATE OF BIRTH (MM/DD/YYYY)	E-MAIL (Optional)	FAX (Optional)

Social Security Number Disclosure: Pursuant to Section 666(a)(13) of Title 42 of the United States Code and California Family Code section 17520, subdivision (d), the Department of Health Services (DHS) is required to collect social security numbers from all applicants for nursing home administrator licenses. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support orders upon request by the Department of Child Support Services and for reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 et seq. Failure to provide your social security number will result in the return of your application. Your social security number will be used by DHS for internal identification, and may be used to verify information on your application, to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.

ANSWER THE FOLLOWING QUESTIONS:

1. **Are you now, or were you, employed as a Nursing Home Administrator in any other state within the U.S.?** YES NO
(If "YES", fill in the information below.) (Provide each State with certification on page 5.)

State: _____	License #: _____	Date of Expiration: _____
State: _____	License #: _____	Date of Expiration: _____
State: _____	License #: _____	Date of Expiration: _____

2. **Former Names?** *(If "YES", list in space below)* YES NO

a. _____

b. _____

c. _____

3. State Examination Requested Date: _____

**** CERTIFICATION—IMPORTANT—PLEASE READ BEFORE SIGNING—If not signed, this application may be rejected. ****

I certify under penalty of the perjury laws of the State of California that the information I have entered on this application is true and correct. I further understand that failure to disclose requested information or any false, incomplete, or incorrect statements may result in denial of this application and/or disqualification from State Examination and/or applying through reciprocity with the Nursing Home Administrator Program. I authorize the employers, U.S. State Agencies and educational institutions identified on this application to release any information they may have concerning my licensure, disciplinary records, employment or education to the State of California Nursing Home Administrator Program. I understand that all the fees are non-refundable.

APPLICANT'S SIGNATURE **	DATE SIGNED **
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APPLICANTS—DO NOT USE THE SPACE BELOW—FOR NHAP USE ONLY

FOR NHAP OFFICE USE ONLY

<p>CASH. # _____</p> <p>NHAP INITIALS _____</p> <p>AMOUNT _____</p>	<table style="width: 100%;"> <tr> <td colspan="3">STATUS</td> </tr> <tr> <td><input type="checkbox"/> Approved</td> <td><input type="checkbox"/> Rejected</td> <td><input type="checkbox"/> Denied <input type="checkbox"/> Missing Information</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Correct Fees</td> <td><input type="checkbox"/> State Certifications</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Fingerprints / Livescan</td> <td><input type="checkbox"/> Provisional License #</td> </tr> <tr> <td><input type="checkbox"/> Unopened Transcripts</td> <td>STAFF</td> <td>DATE PROCESSED</td> </tr> </table>	STATUS			<input type="checkbox"/> Approved	<input type="checkbox"/> Rejected	<input type="checkbox"/> Denied <input type="checkbox"/> Missing Information	<input type="checkbox"/> Correct Fees		<input type="checkbox"/> State Certifications	<input type="checkbox"/> Fingerprints / Livescan		<input type="checkbox"/> Provisional License #	<input type="checkbox"/> Unopened Transcripts	STAFF	DATE PROCESSED
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MASTER’S OR RECIPROCITY APPLICATION FOR NURSING HOME ADMINISTRATOR EXAMINATION

Page 2

APPLICANT’S NAME (Last) _____ (First) _____ (M.I.) _____	SOCIAL SECURITY NUMBER _____
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- 3. Are you now or have you ever been licensed or certified by any other California State Agency?** (If “YES”, please complete below.)
- Agency: _____ License #: _____ Date of Expiration: _____
 Agency: _____ License #: _____ Date of Expiration: _____
 Agency: _____ License #: _____ Date of Expiration: _____
- 4. Have you ever pled guilty or nolo contendere to, or been convicted of any crime (other than minor traffic violations)?** YES NO
 IF THE ANSWER TO THIS QUESTION IS YES, EXPLAIN FULLY ON A SHEET OF PAPER. PROVIDE CERTIFIED COPIES OF ARREST REPORT AND COURT DOCUMENTS THAT INCLUDE THE FOLLOWING AS APPLICABLE: CRIMINAL COMPLAINT, PLEA AND JUDGEMENT, AND PROBATION REPORT. IF THESE RECORDS HAVE BEEN DESTROYED, THE PROGRAM REQUIRES A SIGNED STATEMENT TO THAT FACT ON AGENCY LETTERHEAD, FROM THE AGENCY YOU ARE REQUESTING RECORDS. A CONVICTION WILL NOT NECESSARILY DISQUALIFY YOU.
- 5. Have you ever allowed your NHA license to lapse, or had a temporary license issued by any state licensing authority?** YES NO
 IF YES, IDENTIFY THE STATE AGENCY AND LICENSE NAME AND NUMBER. _____
- 6. Have you ever voluntarily surrendered any other professional license?** YES NO
- 7. Have you ever been the subject of disciplinary action by any licensing agency with regard to any other professional license?** YES NO
 If YES, provide detailed explanation on a separate sheet of paper and attach to application package.
- 8. Within the last five(5) years have you had a license or certification revoked or suspended, other disciplinary action taken, or an application for licensure or certification refused, revoked or suspended by any professional licensing authority of another State, Territory or Country?** YES NO
 If YES, identify agency, state, license name and number, and reason. _____
- 9. If required because of a subpoena for NHA licensure records, can you provide adequate documentation for any of the answers you provided above?** YES NO
- 10. On which basis are you applying for the Nursing Home Administrator Exam** (Check One)?
- Master’s degree in Nursing Home Administration or a related Health Administration field, with an internship/residency in a Long-Term Care Facility.
- Current Licensure as a Nursing Home Administrator in another state.

11. EDUCATION (Must submit unopened Official Transcript(s).)

DID YOU GRADUATE FROM HIGH SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NOT, DO YOU POSSESS A GED OR EQUIVALENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NOT, ENTER THE HIGHEST GRADE YOU COMPLETED
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UNIVERSITY OR COLLEGE NAME--AND LOCATION. BUSINESS, CORRESPONDENCE, TRADE, TECHNICAL, OR SERVICE SCHOOL	COURSE OF STUDY	UNITS COMPLETED		DIPLOMA, DEGREE OR CERTIFICATE OBTAINED	DATE COMPLETED
		SEMESTER	QUARTER		

12. MASTER’S DEGREE WITH INTERNSHIP

EXACT TITLE OF MASTER’S DEGREE _____

WAS YOUR INTERNSHIP IN A LONG-TERM CARE FACILITY? YES NO

NAME AND ADDRESS OF THE FACILITY _____

NUMBER OF WEEKS _____	NUMBER OF HOURS PER WEEK _____
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BRIEFLY DESCRIBE YOUR INTERNSHIP PROGRAM (Attach an extra sheet if necessary)

MASTER’S OR RECIPROCITY APPLICATION FOR NURSING HOME ADMINISTRATOR EXAMINATION

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APPLICANT’S NAME (Last) _____	(First) _____	(M.I.) _____	SOCIAL SECURITY NUMBER _____
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13. SPECIALIZED TRAINING

List in chronological order, from date of graduation from any professional school or program to the present, all professional post-graduate training not including continuing education coursework (i.e., residency, vocational training, practical or clinical training).

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		DID YOU COMPLETE TRAINING?
		FROM (month/year)	TO (month/year)	
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO

14. CITIZENSHIP (Health and Safety Code 1416.22(a))

- (a) Are you a United States Citizen? YES NO
- (b) Are you a Legal Resident? YES NO
- (c) Are you at least 18 years of age or older? YES NO

15. FAMILY SUPPORT

In accordance with the Welfare and Institution Code Section 11350.6, applications for renewal of a license or a new license shall include the applicant’s Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 calendar days delinquent in complying with a child support order, order for spousal support or alimony or repayment obligation. Failure to certify may result in disciplinary or adverse action, and making a false statement may subject the licensee to denial or revocation of examination application.

You **must** check one of the following:

- I am not more than ____ days delinquent in complying with a child support order/order for spousal support or alimony/educational loan repayment obligation.
- I am more then ____ days delinquent in complying with a child support order/order for spousal support or alimony repayment obligation.
- I am current in compliance with a family support order.
- I am not currently under any child support order/spousal support or alimony repayment obligation.

I have reviewed the application package and it is complete with the necessary attachments listed below.

- | | | |
|---|--|--|
| <input type="checkbox"/> 2 X 2 Photo | <input type="checkbox"/> Criminal Conviction Documentation (If Applicable) | <input type="checkbox"/> Live Scan |
| <input type="checkbox"/> Unopened Transcripts | <input type="checkbox"/> Certification forms from each state of licensure | <input type="checkbox"/> Document Verification |

I declare under penalty of perjury under the laws of the State of California that the information furnished in this application is true and correct. By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct, and complete to the best of my knowledge, and that the photograph attached hereto is a true likeness of myself. I hereby authorize the State of California to verify any and all information contained in this application, including information maintained in applicable data banks, and to transmit this information to the licensing authority of the state to which this application is made. I authorize the licensing authority of the State of California to review state files pertaining to my licensure and practice, and all law enforcement records, administrative records, motor vehicle records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization of entities in possession of applicable information to release such information to the licensing authority.

APPLICANT’S SIGNATURE _____	DATE _____
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MASTER’S OR RECIPROCITY APPLICATION FOR NURSING HOME ADMINISTRATOR CERTIFICATION

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TO THE APPLICANT:

If you are applying for CA reciprocity on the basis of your licensure in another state, please have the following certification completed by the licensing board of the state in which you are currently licensed and all other states in which you have ever held a license as a nursing home administrator. (Duplication of this page is permitted)

TO THE STATE BOARD, PROGRAM OR LICENSING AGENCY IN WHICH THE BELOW NAMED APPLICANT IS OR EVER HAS BEEN LICENSED.

_____ is applying for licensure as a nursing home administrator in California. Please furnish the following information concerning the applicant.
(Name)

APPLICANT’S NAME (AS SHOWN ON YOUR RECORDS)

DATE OF BIRTH SOCIAL SECURITY NUMBER

ORIGINAL LICENSE NUMBER DATE ISSUED EXPIRATION DATE

- | | |
|---|---|
| <p>1. Has the licensee ever had any application for any professional license refused or denied by your licensing authority?</p> <p>2. Has the licensee ever been refused or denied the privilege of taking an examination required for any professional licensure?</p> <p>3. Has the licensee ever been dropped, suspended, placed on probation, fined or requested to resign license in lieu of adverse action by your states licensing authority?
If YES, list offense, duration of discipline, discipline type, date(s) of discipline, and completion date(s).

_____</p> <p>4. Has the applicants NHA license ever been revoked?</p> <p>5. Has the licensee ever been the subject of disciplinary action with regard to your states NHA license, been sanctioned by any other licensing authority, association, licensed facility, or staff of such facility?</p> <p>6. Are there any unresolved or pending complaints against the licensee with any licensing agency in your state?
Length of time needed to resolve these?_____.</p> <p>7. The number, type, and date(s) of complaints filed against licensee:_____.</p> <p>8. Does the applicant comply with your states regulatory requirements governing long-term care administrators or facilities?</p> <p>9. Were any citations issued against the licensee? Number of citations that were upheld against the licensee _____ . Citation level (AA, A, B, etc.) _____.</p> <p>10. Candidate’s National Examination score _____.</p> <p>11. Did licensee complete an Administrator-in-Training Program in your state?
If YES, number of hours completed:_____.</p> <p>12. What is/was the licensee’s length of time licensed in your state?</p> <p>13. Is the licensee a preceptor in your state?</p> <p>14. Is the licensee’s Continuing Education current?</p> | <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
|---|---|

SIGNATURE OF EXECUTIVE OFFICER OR DIRECTOR DATE SIGNED

NAME OF EXECUTIVE OFFICER (PLEASE PRINT OR TYPE)

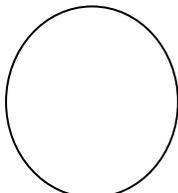
AGENCY

ADDRESS (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

TELEPHONE NUMBER FAX NUMBER

WEBSITE E-MAIL ADDRESS

**STATE BOARD: PLEASE RETURN THIS COMPLETED FORM DIRECTLY TO THE: NURSING HOME ADMINISTRATOR PROGRAM
P.O. BOX 997416, MS 3302
SACRAMENTO, CA 95899-7416**



PLACE SEAL HERE

LIVE SCAN FORM INSTRUCTIONS

Fingerprints can be scanned at any authorized Live Scan (LS) agency. For LS agency information and locations, you can access the Internet at: <https://oag.ca.gov/fingerprints/locations>

Please complete the following information on the LS form:

1. Full *Name of Applicant*
2. Any aliases such as a maiden name (AKA's)
3. Date of birth (DOB)
4. Check applicant box for sex (SEX)
5. Place of birth (POB)
6. Social Security number (SOC)
7. California driver's license number (CDL No.)
8. Check *DOJ* and *FBI* boxes for *Level of Service*
9. Physical description (HT, WT, EYE Color, and Hair Color) using the appropriate abbreviations listed.

IMPORTANT:

The Live Scan form should include an *ORI*, *Mail Code*, and Misc. No. *BIL* – numbers. If any of these numbers are missing, please contact the Program prior to making an appointment at a LS agency! Employer section must be left blank.

Fees

The cost for processing a criminal record check is: State fee, \$32.00; and Federal fee, \$19.00. You must include payment with the application (\$51 background clearance fee). You should be paying for the rolling fee only at the time of your Live Scan.

Submit a copy of the completed live scan form to:

Nursing Home Administrator Program
P. O. Box 997416, MS 3302
Sacramento, CA 95899-7416

If you have any questions, please contact the Program at (916) 552-8780 or by electronic mail at NHAP@cdph.ca.gov.



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A1098
ORI (Code assigned by DOJ)

License Certification or Permit
Authorized Applicant Type

Nursing Home Administrator
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Nursing Home Administrator Program
Agency Authorized to Receive Criminal Record Information

03857
Mail Code (five-digit code assigned by DOJ)

MS 3302, P.O. Box 997416
Street Address or P.O. Box

(Leave blank)
Contact Name (mandatory for all school submissions)

Sacramento CA 95899-7416
City State ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name Middle Initial Suffix

Other Name (AKA or Alias) Last

First Suffix

Date of Birth Sex Male Female

Driver's License Number

Height Weight Eye Color Hair Color

Billing Number 141823
(Agency Billing Number)

Place of Birth (State or Country) Social Security Number

Misc. Number
(Other Identification Number)

Home Address Street Address or P.O. Box

City State ZIP Code

Your Number: _____
OCA Number (Agency Identifying Number)

Level of Service: DOJ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

(Leave blank)
Employer Name

(Leave blank)
Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City State ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency LSID

ATI Number Amount Collected/Billed