In this space, attach a recent photo, sized approximately 2"by 2", clearly picturing the applicant's face.

(FOR IDENTIFICATION PURPOSES ONLY)

APPLICATION FOR PROVISIONAL LICENSE

Return this completed form, with a check or Money Order for the Provisional License fee of $370, Fingerprint card processing fee $51, Processing fee $40 (Total $461)-Payable to NHAP.

Please return to the following address:

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

PRINT OR TYPE

APPLICANT'S NAME *(Last)* *(First)* *(M.I.)*	SOCIAL SECURITY NUMBER *
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. ☐ Current ☐ Permanent ☐ Business	DAYTIME PHONE	EVENING PHONE
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:
State: _____ License #: _____ Date of Expiration:

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

a. _____
b. _____
c. _____

**** 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 Provisional License 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 the California Provisional License is valid for 12 months only, it is not renewable. I must take and pass the State Examination within the 12-month time frame. I further understand that if I do not pass the examination during that time, I will have to reapply through regular reciprocity procedures with NHAP and I will not be able to continue to work in California without a CA NHA License. I also understand that all the fees are non-refundable.***

APPLICANT'S SIGNATURE **	DATE SIGNED **

APPLICANTS—DO NOT USE THE SPACE BELOW—FOR NHAP USE ONLY

FOR NHAP OFFICE USE ONLY

CASH. # _____	STATUS ☐ Approved ☐ Rejected ☐ Reciprocity ☐ Missing Information	
NHAP INITIALS _____	☐ Correct Fees	☐ State Certifications
AMOUNT _____	☐ Fingerprints / Livescan	☐ Provisional License #
	STAFF	DATE PROCESSED

NHAP PROVISIONAL LICENSE APPLICATION

APPLICANT'S NAME *(Last)* *(First)* *(M.I.)*	SOCIAL SECURITY NUMBER

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. Health and Safety Code, Section 1416.38(d),(1) requires each applicant for Provisional License to provide "a statement of health consistent with an ability to perform the duties of a Nursing Home Administrator." Do you meet these requirements? ☐ YES ☐ NO

9. 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. _____

10. 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

11. EDUCATION

DID YOU GRADUATE FROM HIGH SCHOOL?	IF NOT, DO YOU POSSESS A GED OR EQUIVALENT?	IF NOT, ENTER THE HIGHEST GRADE YOU COMPLETED
☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	

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. NURSING HOME WORK EXPERIENCE *(Licensed NHA's)*

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ YES ☐ NO
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	

DEPT. OF NURSING HOME	FACILITY ADDRESS, CITY, STATE, ZIP

DUTIES AND RESPONSIBILITIES

Check Appropriate Box

☐ I am authorized and have personally verified the information from records on file at the facility.	FROM:	TO:
☐ I have personal knowledge of this work experience because I worked at the same facility as the applicant.	FROM:	TO:
**** Signature of Licensed NHA, Physician, or RN** _____	**LIC. #** _____	**DATE:**

NHAP PROVISIONAL LICENSE APPLICATION

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER

13. NURSING HOME WORK EXPERIENCE *(Licensed NHA's)*

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ YES ☐ NO
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	
DEPT. OF NURSING HOME		FACILITY ADDRESS, CITY, STATE, ZIP	

DUTIES AND RESPONSIBILITIES

Check Appropriate Box

☐ I am authorized and have personally verified the information from records on file at the facility.	FROM:	TO:
☐ I have personal knowledge of this work experience because I worked at the same facility as the applicant.	FROM:	TO:
**** Signature of Licensed NHA, Physician, or RN** _____	**LIC. #** _____	**DATE:**

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ YES ☐ NO
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	
DEPT. OF NURSING HOME		FACILITY ADDRESS, CITY, STATE, ZIP	

DUTIES AND RESPONSIBILITIES

Check Appropriate Box

☐ I am authorized and have personally verified the information from records on file at the facility.	FROM:	TO:
☐ I have personal knowledge of this work experience because I worked at the same facility as the applicant.	FROM:	TO:
**** Signature of Licensed NHA, Physician, or RN** _____	**LIC. #** _____	**DATE:**

14. 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)	
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

NHAP PROVISIONAL LICENSE APPLICATION

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER

15. 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**

16. 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 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 provisional license.

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/educational loan 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.

17. Do you have a job offer for a NHA position with a nursing home or long-term care facility in the State of California? ☐ **YES** ☐ **NO**
If **YES**, please provide facility and contact information below.

18. TO BE COMPLETED BY FACILITY EMPLOYER

NAME OF APPLICANT *(LAST)*	*(FIRST)*	*(MIDDLE)*

FACILITY PHONE NUMBER	JOB TITLE OFFERED	DATE TO BEGIN

NAME AND ADDRESS OF FACILITY, OFFICE OR CORPORATION

NAME, ADDRESS, AND PHONE NUMBER OF SNF / ICF WHERE JOB WILL BE HELD	DATE
CONTACT PERSON AT FACILITY (Name, Title)	PHONE NUMBER:

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

☐ 2 X 2 Photo	☐ Criminal Conviction Documentation	☐ Fingerprint Cards x 2 *OR* ☐ Live Scan Form
☐ Application Package Fee	☐ Certification forms from each state of licensure	
☐ Facility Employer Section Completed (16)	☐ Official Transcripts	

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 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, 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**

NHAP PROVISIONAL LICENSE APPLICATION CERTIFICATION

TO THE APPLICANT:

If you are applying for the CA NHA Provisional License 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

1. **Has the licensee ever had any application for any professional license refused or denied by your licensing authority?** ☐ **YES** ☐ **NO**
2. **Has the licensee ever been refused or denied the privilege of taking an examination required for any professional licensure?** ☐ **YES** ☐ **NO**
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?** ☐ **YES** ☐ **NO**
   If **YES**, list offense, duration of discipline, discipline type, date(s) of discipline, and completion date(s).
   _____
   _____
4. **Has the applicants NHA license ever been revoked?** ☐ **YES** ☐ **NO**
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?** ☐ **YES** ☐ **NO**
6. **Are there any unresolved or pending complaints against the licensee with any licensing agency in your state?** ☐ **YES** ☐ **NO**
   Length of time needed to resolve these?_____.
7. **The number, type, and date(s) of complaints filed against licensee**:_____.
   _____.
8. **Does the applicant comply with your states regulatory requirements governing long-term care administrators or facilities?** ☐ **YES** ☐ **NO**
9. **Were any citations issued against the licensee? Number of citations that were upheld against the licensee** ☐ **YES** ☐ **NO**
   _____. Citation level (AA, A, B, etc.) ._____.
10. **Candidate's National Examination score _____.**
11. **Did licensee complete an Administrator-in-Training Program in your state?** ☐ **YES** ☐ **NO**
    If **YES**, number of hours completed: **_____.**
12. **What is/was the licensee's length of time licensed in your state?**
13. **Is the licensee a preceptor in your state?** ☐ **YES** ☐ **NO**
14. **Is the licensee's Continuing Education current?** ☐ **YES** ☐ **NO**

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