California Department of Public Health (CDPH)
Nursing Home Administrator Program (NHAP)
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416
(916) 552-8780 FAX (916) 552-8777
NHAP@cdph.ca.gov

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)

Master's or Reciprocity Application for Nursing Home Administrator Examination

Return this completed form with a check or money order (made payable to NHAP) with the appropriate fees **(Initial License Fee, Live Scan Fee, Reciprocity Licensure Application Fee and Written State Exam Fee)** to the following address:

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

For a current ***Fee List and Detailed Fee Analysis***, please visit our website at: www.cdph.ca.gov/certlic/occupations/Pages/NursingHomeAdministrator.aspx

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

CURRENT ADDRESS (If P.O. Box, must provide street address)	(City)	(State)	(Zip Code)
PERMANENT MAILING ADDRESS (If different from address listed above)	(City)	(State)	(Zip Code)
BUSINESS MAILING ADDRESS	(City)	(State)	(Zip Code)
IDENTIFY PREFERRED PUBLIC RECORD ADDRESS ☐ Current ☐ Permanent ☐ Business	DAYTIME TELEPHONE NUMBER	EVENING TELEPHONE NUMBER	
DATE OF BIRTH (MM/DD/YYYY)	E-MAIL	FAX NUMBER (Optional)	

Please identify the way you would like your name to appear on you license: (First, Middle, Last)

*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 California Department of Public Health (CDPH) 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, collection of delinquent State taxes if applicant appears on the Franchise Tax Board's top 500 delinquent taxpayers list pursuant to Business Codes Section 494.5 Subdivision (4), and for reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR Section 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 CDPH 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 the Verification of Nursing Home Administrator License page.)
   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 Date Requested: _____

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 the State Examination and/or applying through reciprocity with the NHAP. 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 NHA P. ***I also understand that all the fees are non-refundable and non-transferable*** *and will be forfeited.*

APPLICANT'S SIGNATURE : _____ DATE : _____

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

		STATUS ☐ Approved ☐ Rejected ☐ Denied ☐ Missing Information	
CASH #		☐ Correct Fees	☐ State Certification
NHAP INITIALS		☐ Fingerprints/Live Scan	☐ Provisional License #
AMOUNT		☐ Unopened Transcripts	STAFF / DATE PROCESSED

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

4. Are you know, or have your ever been licensed or certified by any other California State Agency? (If "**Yes,**" please complete below.) ☐ Yes ☐ No

Agency: _____ License #: _____ Date of expiration: _____
Agency: _____ License #: _____ Date of expiration: _____
Agency: _____ License #: _____ Date of expiration: _____

5. 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 JUDGMENT, AND PROBATION REPORT. IF THESE RECORDS HAVE BEEN DESTROYED, THE PROGRAM REQUIRES A SIGNED STATEMENT TO THAT FACT FROM THE AGENCY YOU ARE REQUESTING YOUR INFORMATION. A CONVICTION WILL NOT NECESSARILY DISQUALIFY YOU.***

6. 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, license name and number: _____

7. Have you ever voluntarily surrendered any other professional license? ☐ Yes ☐ No

8. 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 separate sheet of paper and attach to this application package.

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 the agency, state license name, 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. 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.

12. EDUCATION

DID YOU GRADUATE FROM HIGH SCHOOL? ☐ Yes ☐ No

IF NOT, DID YOU POSSESS A GED OR EQUIVALENT? ☐ Yes ☐ No

IF NOT, ENTER THE HIGHEST GRADE YOU COMPLETED: _____

UNIVERSITY OR COLLEGE NAME-AND LOCATION, BUSINESS, CORRESPONDENCE, TRADE, TECHNICAL, OR SERVICE SCHOOL	COURSE	UNITS		DIPLOMA, DEGREE OR CERTIFICATE OBTAINED	DATE COMPLETED
		SEMESTER	QUARTER		

13. MASTER'S DEGREE WITH INTERNSHIP

EXACT TITLE OF MASTER'S DEGREE

WAS YOUR INTERNSHIP IN A LONG-TERM FACILITY? ☐ Yes ☐ No

NAME AND ADDRESS OF THE FACILITY

NUMBER OF WEEKS	NUMBER OF HOURS PER WEEK

BRIEFLY DESCRIBE YOUR INTERNSHIP PROGRAM (Attach an extra sheet if necessary)

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

14. SPECIALIZED TRAINING

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

INSTITUTION NAME	LOCATION (City and State or County)	DATES OF ATTENDANCE FROM (MONTH/YEAR)	TO (MONTH/YEAR)	DID YOU COMPLETE TRAINING?

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 eighteen (18) years of age or older? ☐ Yes ☐ No

16. FAMILY SUPPORT

In accordance with the Welfare and Institutions 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 thirty (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 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 than ____ days delinquent in complying with a child support order/order for spousal support or alimony/educational loan repayment obligation.

☐ I am currently in compliance with a family support order.

☐ I am not currently under any child support order/spousal support or alimony or 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 ***(To be completed by facility employer):***

APPLICANT'S NAME (Last)	(First)	(Middle)
FACILITY PHONE NUMBER	JOB TITLE OFFERED	DATE TO BEGIN

NAME OF FACILITY, OFFICE OR CORPORATION		TELEPHONE NUMBER	
ADDRESS OF FACILITY, OFFICE OR CORPORATION (NUMBER AND STREET)	(City)	(State)	(Zip Code)
NAME OF SNF/ICF WHERE JOB WILL BE HELD		TELEPHONE NUMBER	
ADDRESS OF SNF/ICF WHERE JOB WILL BE HELD (NUMBER AND STREET)	(City)	(State)	(Zip Code)
CONTACT PERSON AT FACILITY (Name and Title)		TELEPHONE NUMBER	

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

☐ 2 X 2 Photo ☐ Criminal Conviction Documentation (if applicable) ☐ Live Scan

☐ Facility Employer Section Completed (16) ☐ Certification form from each state of licensure ☐ Official Transcripts (unopened)

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: _____

VERIFICATION OF NURSING HOME ADMINISTRATOR LICENSE

TO THE APPLICANT:
If you are applying for the California reciprocity on the basis of your licensure in another state, please have the following certification verification 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 SIGNATURE (AS SHOWN ON YOUR RECORDS)		
DATE OF BIRTH (MM/DD/YYYY)	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 state's licensing authority? ☐ Yes ☐ No
   If "**Yes,**" list offense, duration of discipline, discipline type, date(s) of discipline and completion date(s): _____
   _____
   _____
4. Has the applicant's NHA license ever been revoked? ☐ Yes ☐ No
5. Has the licensee ever been the subject of disciplinary action with regard to your state's 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 state's 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 OR EXECUTIVE OFFICER OR DIRECTOR			DATE SIGNED
NAME OF EXECUTIVE OFFICER (PLEASE PRINT OR TYPE)			
AGENCY NAME			
ADDRESS (Number and Street)	(City)	(State)	(Zip Code)
TELEPHONE NUMBER	FAX NUMBER		
WEBSITE	E-MAIL ADDRESS		

STATE BOARD: PLEASE COMPLETE AND RETURN FORM DIRECTLY TO:

NURSING HOME ADMINISTRATOR PROGRAM
P.O. BOX 997416, MS 3302
SACRAMENTO, CA 95899-7416

STATE SEAL HERE