State of California – Health and Human Services Agency
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) 636-6108
NHAP@cdph.ca.gov

Application for Provisional License

Return this completed form with a completed CDPH 524 and check or money order with the appropriate fees 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: http://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/NHAPFees.aspx

Answer the following questions:

1. 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

2. Nursing Home Work Experience (Licensed NHA's)
(Please provide current or recent employment experience within the last five years as a licensed nursing home administrator)

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:
Print Name of licensed NHA, Physician, or RN	**Email:**	**Phone Number:**
**** Signature of Licensed NHA, Physician, or RN:** _____	**Lic. #** _____	**Date:** _____

3. Nursing Home Work Experience (Licensed NHA's)
(Please provide current or recent employment experience within the last five years as a licensed nursing home administrator)

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:
Print Name of licensed NHA, Physician, or RN	**Email:**	**Phone Number:**
**** Signature of Licensed NHA, Physician, or RN: _____**	**Lic. # _____**	**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. 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. 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 hereby authorize 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 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 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 NHAP. This application and signature shall act as authorization of entities in possession of applicable information to release such information to the licensing authority. I also understand that all the fees are non-refundable and non-transferable and will be forfeited.

Applicant's Signature:	Date: