

Provisional License 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 attain a Provisional Nursing Home Administrator License, you must:

- Complete the Provisional License Application and submit all required documentation.
- Must be at least 18 years of age, be a citizen of the United State 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.

Provisional License Application Checklist

APPLICATION FEE \$461: Submit a check money order, or cashier's check in the amount of \$461 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. **Please note: The provisional license is good for only one year from date of approval. If within that year the provisional licensee fails to pass the state examination, the provisional license shall expire and no further reciprocity accommodations shall be allowed. The provisional license may not be renewed or extended. At the expiration of the provisional license the applicant may seek licensure in this state through standard procedures. (Per Health & Safety Code 1416.40(e))**

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.

WORK EXPERIENCE: You must provide satisfactory evidence of current or recent employment experience (your W2 is evidence of employment) within the last five years as a licensed nursing home administrator. (Per Health & Safety Code 1416.40(d)(4))

LICENSE VERIFICATION: Have 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 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

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 *
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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. <input type="checkbox"/> Current <input type="checkbox"/> Permanent <input type="checkbox"/> 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:

- 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: _____
- 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 **
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APPLICANTS—DO NOT USE THE SPACE BELOW—FOR NHAP USE ONLY

FOR NHAP OFFICE USE ONLY

CASH. # _____ NHAP INITIALS _____ AMOUNT _____	<table border="1" style="width:100%"> <tr> <td colspan="2">STATUS</td> </tr> <tr> <td><input type="checkbox"/> Approved</td> <td><input type="checkbox"/> Reciprocity</td> </tr> <tr> <td><input type="checkbox"/> Rejected</td> <td><input type="checkbox"/> Missing Information</td> </tr> <tr> <td><input type="checkbox"/> Correct Fees</td> <td><input type="checkbox"/> State Certifications</td> </tr> <tr> <td><input type="checkbox"/> Fingerprints / Livescan</td> <td><input type="checkbox"/> Provisional License #</td> </tr> <tr> <td>STAFF</td> <td>DATE PROCESSED</td> </tr> </table>	STATUS		<input type="checkbox"/> Approved	<input type="checkbox"/> Reciprocity	<input type="checkbox"/> Rejected	<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 #	STAFF	DATE PROCESSED
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STAFF	DATE PROCESSED												

NHAP PROVISIONAL LICENSE APPLICATION

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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. 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? <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. NURSING HOME WORK EXPERIENCE (Licensed NHA's)

FROM (M/D/Y)	TO (M/D/Y)	JOB TITLE/CLASSIFICATION	SUPERVISORY? <input type="checkbox"/> YES <input type="checkbox"/> 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

<input type="checkbox"/> I am authorized and have personally verified the information from records on file at the facility.	FROM:	TO:
<input type="checkbox"/> 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: _____

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APPLICANT'S NAME (Last)	(First)	(M.I.)	SOCIAL SECURITY NUMBER
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13. NURSING HOME WORK EXPERIENCE (Licensed NHA's)

FROM (M/D/Y)	TO (M/D/Y)	JOB TITLE/CLASSIFICATION	SUPERVISORY? <input type="checkbox"/> YES <input type="checkbox"/> 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

<input type="checkbox"/> I am authorized and have personally verified the information from records on file at the facility.	FROM:	TO:
<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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

<input type="checkbox"/> I am authorized and have personally verified the information from records on file at the facility.	FROM:	TO:
<input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO
		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

NHAP PROVISIONAL LICENSE APPLICATION CERTIFICATION

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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

- | | |
|--|--|
| <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
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NAME OF EXECUTIVE OFFICER (PLEASE PRINT OR TYPE)

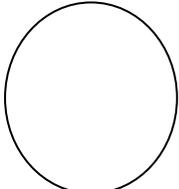
AGENCY

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

TELEPHONE NUMBER	FAX NUMBER
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WEBSITE	E-MAIL ADDRESS
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**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 AIT Application or Exam Application. Application **must** include one check for the application or exam and criminal record check fees.

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