

APPLICATION FOR NURSING HOME ADMINISTRATOR LICENSE

Return this completed form with a check or money order (made payable to NHAP) with the appropriate fees to the following address:

Nursing Home Administrators 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/certlic/occupations/Pages/NursingHomeAdministrator.aspx>

APPLICANT'S NAME (Last)	(First)	(M.I.)	SOCIAL SECURITY NUMBER*
MAILING ADDRESS (Number)		(Street)	
(City)	(County)	(State)	(Zip Code)
E-MAIL ADDRESS		DRIVER'S LICENSE NUMBER	DATE OF BIRTH (MM/DD/YYYY)

*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.

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 SEPARATE 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.**

I am enclosing a check or money order in the amount of \$ _____

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

AN APPLICANT'S ELIGIBILITY FOR LICENSURE SHALL BE DEPENDENT ON SUCCESSFUL COMPLETION OF THE NATIONAL AND STATE EXAMINATIONS.

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) days delinquent in complying with a child support order, order for spousal support or alimony. Failure to certify may result in disciplinary or adverse action, and making a false statement may subject the licensee's license to denial or revocation actions by NHAP.

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

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

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

I certify under the penalty of the perjury laws of the State of California that the information I have entered on this application is true and correct to the best of my knowledge. I further understand that any false, incomplete, or incorrect statements may result in denial of this application with the NHAP. I understand that if I fail to appear for the examination as scheduled, **the fees are non-refundable and non-transferable and will be forfeited.**

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

CASH # _____ NHAP INITIALS _____ AMOUNT _____	STATUS <input type="checkbox"/> Approved <input type="checkbox"/> Rejected <input type="checkbox"/> Denied <input type="checkbox"/> Training Requirements <input type="checkbox"/> AIT # _____ STAFF _____ DATE PROCESSED _____
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All information requested by the application is required by the California Department of Public Health, (NHAP). Maintenance of the information requested on this form is authorized by the Health and Safety Code. **Failure to provide any of the required information will result in the application being rejected as incomplete.** For more information or access to records containing your personal information maintained by CDPH, contact the NHAP, P.O. Box 997416, MS 3302, Sacramento, CA 94899-7416, (916) 552-8780.