

REQUEST FOR PROVIDER RENEWAL

Return this completed form with a check or money order (made payable to NHAP) 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**, please visit our website at: www.cdph.ca.gov/certlic/occupations/Pages/NursingHomeAdministrator.aspx

PROVIDER'S NAME	PROVIDER NUMBER	TELEPHONE NUMBER	
ADDRESS (Number and Street Name)	(City)	(State)	(Zip Code)
PROVIDER'S E-MAIL ADDRESS			

Maintenance of the information requested on this form is authorized by the Health and Safety Code. Signature below certifies this is a renewal of a Continuing Education Provider previously approved within the last two-year period. Failure to provide any of the required information will result in the application being rejected as incomplete.

APPLICANT'S SIGNATURE	DATE
NAME/TITLE	

FOR NHAP OFFICE USE ONLY

(Do Not Write Below This Line)

CASH #	AMOUNT	NHAP STAFF INITIALS
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