STATE OF NEVADA
BOARD OF EXAMINERS
FOR LONG TERM CARE ADMINISTRATORS
3157 N. Rainbow Boulevard, No. 313
Las Vegas, Nevada 89108
Phone: 702-486-5445 Fax: 702-486-5439
E-mail: beltca@beltca.nv.gov
Website: http://beltca.nv.gov

CHANGE/ADDITION OF FACILITY

***** I M P O R T A N T *****

Remember, your license belongs to you! By assuming the position of named administrator of a facility, you accept the total responsibility of insuring the proper operations of the facility at all times.

Please be reminded that NAC 654.181 provides that each person licensed as a nursing facility administrator or an administrator of a residential facility for groups shall notify the Board in writing any time he/she changes his/her contact information including home address, phone number, cell phone number and email address or changes his/her affiliation with a facility within 15 days after such an event. A Licensee will be subject to a fine of $500.00 for a first offense if the above rule is not adhered to.

Effective February 20, 2013, NAC 654.250.6 requires a nursing facility administrator or an administrator of a residential facility for groups to surrender and return a license to the Board not later than 15 calendar days after terminating his or her affiliation with a named facility for any reason. Licensees will be subject to a fine of $500.00 for the first violation and at least $1,000.00 for a second or subsequent violation, but will not exceed $10,000 for each violation.

Requests for licenses naming a facility cannot be issued until the license from the previous administrator is received by BELTCA.

A fee of $**100.00** is required for the issuance of a new license for each new facility and/or a new license.

The signature of the facility owner or owner's representative is required for all new facilities requested by a licensee.

PLEASE PRINT LEGIBLY AND PROVIDE COMPLETE INFORMATION.

LICENSEE NAME _____ LICENSE NO. _____

_____
(*Home Street Address*) (*City, State, Zip)*

HOME PHONE_____CELL _____ PERSONAL E-MAIL _____

FACILITY

NAME OF NEW FACILITY _____LICENSE NO. _____NO.OF BEDS_____

_____
(Street Address) *(City, State, Zip)*

TEL. NO. _____ FAX NO. _____ FACILITY E-MAIL_____

A CHANGE APPLICATION WAS SUBMITTED TO HCQC ON _____ COPY ATTACHED.

SIGNATURE OF LICENSEE _____EFFECTIVE DATE _____

AUTHORIZED BY: _____
Signature of Facility Owner or Owner Representative

_____
Print Name and Title