

Place Photo
Here
Passport Size

NEVADA STATE BOARD OF EXAMINERS
FOR
LONG TERM CARE ADMINISTRATORS
3157 N. Rainbow Blvd., #313
Las Vegas, Nevada 89108
Phone: (702) 486-5445
Fax : (702) 486-5439

RESIDENTIAL/NURSING FACILITY ADMINISTRATOR

APPLICATION FOR LICENSURE
(Applications must be printed or typed)

ALL APPLICATIONS FOR LICENSURE MUST BE COMPLETED WITHIN ONE (1) YEAR OF THE ORIGINAL DATE OF SUBMITTAL. APPLICATIONS NOT COMPLETED WITHIN ONE (1) YEAR WILL BE CONSIDERED VOID.

I. APPLICANT IDENTIFYING INFORMATION

PLEASE CHECK ONE:

RESIDENTIAL FACILITY ADMINISTRATOR _____ NURSING FACILITY ADMINISTRATOR _____

1. Name _____
Last/Family First/Given Middle Maiden
2. Other Names Used _____ Mother's Maiden Name _____
Last First
3. Social Security Number _____ 4. Telephone No. Home _____
5. Business Telephone No. _____ 6. Cell Phone: _____
7. Personal E-mail: _____
8. Address _____
Number/Street Apartment # City State Zip
9. Date of Birth _____ 10.. Place of Birth _____ 11. United States Citizen? Yes ___ No ___

II. RECORD OF LICENSURE INFORMATION

Licenses/Certificates: List all licenses, registrations or certifications issued by any state, province or country you now hold, in any capacity, in any jurisdiction (Example: RN, LPN, etc.)?

License Type	State	License/Certificate Number	Active/ Inactive Disciplined	By Exam or Endorsement	Expiration Date
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

4. Have you failed a NAB Residential/Nursing Facility Administrator's Exam in any other state? Yes _____ No _____

If yes, how many times? _____ In what state? _____

5. Do you have difficulty reading or writing English without assistance? Yes _____ No _____

III. ONLY NURSING FACILITY ADMINISTRATOR APPLICANTS MUST COMPLETE THE FOLLOWING

Have you completed at least 1,000 hours in a program for training administrators and/or an internship or residency in a facility providing long-term care approved by a **Board of Licensure for Nursing Facilities Administrators**?
_____ Yes _____ No

If YES, provide the name and address of the program, a description of the course outline and a copy of transcripts or certificate received.

IV. PERSONAL HISTORY INFORMATION (All Applicants)

In order to protect the public and comply with the American Disabilities Act, please answer the following questions. If the response is yes, carefully read the information after each question and provide all necessary documentation. Your application will not be considered complete without it.

1. Has your license, registration or certification in any state ever been denied, revoked, suspended, reprimanded, fined, surrendered, restricted, limited or placed on probation? Yes _____ No _____

If the answer is yes, you must submit a detailed letter of explanation of the action, state where the action took place and the circumstances leading to the action and copies of records and orders from the agency that took the action identifying the allegations, action taken and current action status.

2. Have you ever, since attaining the age of 18 years, been charged, even if charges were dropped, or dismissed, or convicted of a criminal offense whether a felony, gross misdemeanor or misdemeanor, placed on probation, or granted deferred adjudication, pretrial diversion or had records sealed or expunged, or advised by an attorney that you do not have to list the conviction, in any jurisdiction? Yes _____ No _____

PLEASE NOTE: FAILURE TO FULLY AND COMPLETELY DISCLOSE ANY FORMER CHARGES, ARRESTS OR CONVICTIONS MAY RESULT IN DENIAL OF YOUR LICENSE.

If you have any question as to how to respond to this question, please call the Board Office at (702) 486-5445 for clarification.

If the answer is yes, you must submit the following:

- a. A detailed letter of explanation including date of offense, circumstances leading to arrest, conviction, sentence, additional convictions and current status of sentence.
- b. Copies of court documents identifying actual conviction and sentence
- c. A letter from parole/probation officer regarding compliance with requirements or copy of document identifying completion of sentence.
- d. A criminal history printout from a FBI fingerprint check.

3. Within the past five years have you been diagnosed, treated or hospitalized for a psychiatric or mental health condition that could/may result in your not being able to practice the essential job functions of a Residential/Nursing Facility Administrator?

Yes _____ No _____

If the answer is yes you must submit the following:

- a. A detailed letter of explanation including diagnosis, past treatment efforts (inpatient or out patient), date of last treatment and current treatment plan.
- b. Documentation from treating practitioners regarding diagnosis (Axis I - V), medications, treatment modality, treatment plan, current mental status and statement regarding ability to function, cope with a stressful situation or reason and make sound judgments.

4. Within the past five years have you been diagnosed as having a physical or medical condition which will result in your not being able to practice the essential job function of a Residential/Nursing Facility Administrator?

Yes _____ No _____

If the answer is yes you must submit the following:

- a. A detailed letter of explanation of the condition and how it may interfere with your ability to practice.
- b. A letter from your treating practitioner regarding diagnosis, extent of the condition and your ability to practice.

A "YES" ANSWER TO ANY OF THE ABOVE QUESTIONS WILL AFFECT THE PROCESSING OF YOUR APPLICATION AND MAY RESULT IN ISSUING AN UNRESTRICTED, LIMITED OR RESTRICTED LICENSE. FAILURE TO ANSWER TRUTHFULLY IS GROUNDS FOR A FRAUDULENT APPLICATION AND MAY RESULT IN DISCIPLINARY ACTION.

V. EDUCATION INFORMATION:

Please complete the form below regarding your education.

<u>University/College/ High School/Other</u>	<u>Location</u>	<u>Month & Year Attended</u>	<u>Degree Diploma/Other</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Note: An official copy of your grade transcripts and/or degree/diploma must be provided by the granting institution.

VI. CHILD SUPPORT INFORMATION

Please mark the appropriate response (**failure to mark one of the three will result in denial of the application**):

_____ I am not subject to a court order for the support of a child.

_____ I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ I am subject to a court order for the support of one or more children and am **not** in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Applicant's Social Security number: _____

Applicant's Signature _____ Date _____ 20 _____

VII. WORK HISTORY/PRACTICAL EXPERIENCE:

Please describe your work experience for the last 10 years beginning with your most recent position. If you were unemployed for longer than three (3) months, list the dates and your address in the experience block. You must complete the forms below. "SEE RESUME" is not acceptable.

Dates of Employment : From _____ To: Present
Mo. Day

Name of Employer/Business: _____ Address: _____

Phone Number: () _____ Type of Business: _____

Your Position/Title: _____ Number of Employees Supervised: _____

Briefly Describe Your Specific Duties: _____

Reason for Leaving: _____

Dates of Employment : From _____ To: _____
Mo. Day

Name of Employer/Business: _____ Address: _____

Phone Number: () _____ Type of Business: _____

Your Position/Title: _____ Number of Employees Supervised: _____

Briefly Describe Your Specific Duties: _____

Reason for Leaving: _____

Dates of Employment : From _____ To: _____
Mo. Day

Name of Employer/Business: _____ Address: _____

Phone Number: () _____ Type of Business: _____

Your Position/Title: _____ Number of Employees Supervised: _____

Briefly Describe Your Specific Duties: _____

Reason for Leaving: _____

If needed, please use an additional sheet for work history information for 10-year period.

**NEVADA STATE BOARD OF EXAMINERS
FOR
LONG TERM CARE ADMINISTRATORS
3157 N. Rainbow Blvd., #313
Las Vegas, Nevada 89108
Phone : (702) 486-5445
Fax: (702) 486-5439**

DESCRIPTION:

Affix
Passport-Size
Photo Here

Color of Hair: _____
Color of Eyes: _____
Height: _____
Weight: _____
Date Photo was Taken: _____

VIII. AFFIDAVIT

I declare that I am the applicant described and identified in this application for licensure in the State of Nevada.

I declare that I am qualified in all respects for the license for which I am applying in this application.

To the best of my knowledge, the information contained in this application and its supporting documents is free of fraud, misrepresentation or omission of material fact.

To the best of my knowledge, the information contained in this application and its supporting document(s) is truthful, correct and complete; and discloses all material facts regarding myself and associated individuals necessary to properly evaluate my qualifications for licensure.

I will ensure that any information subsequently submitted to the Board in conjunction with this application or its supporting documents meets the same standard as set forth above.

I understand it is unlawful and punishable by law to apply for or obtain a license or otherwise deal with the Board of Examiners for Long Term Care Administrators or a licensing board through the use of fraud, forgery or intentional deception, misrepresentation, misstatement or omission.

I authorize the Board of Examiners for Long Term Care Administrators to review and copy any documents pertaining to my past or present employment or character.

I release my past and present employers, references and all other persons whomsoever from any damage because of furnishing said information.

Attached is a copy of my driver's license or other photo identification.

Signed by: _____ Date: _____

Applicant's Signature _____

**NEVADA STATE BOARD OF EXAMINERS
FOR
LONG TERM CARE ADMINISTRATORS
3157 N. Rainbow Blvd., #313
Las Vegas, Nevada 89108
Phone: (702) 486-5445
Fax: (702) 486-5439**

IX. ADMINISTRATOR FINGERPRINT PROCESSING INSTRUCTIONS (CARDS)

As an applicant for licensure with the Board of Examiners for Long-Term Care, it is your responsibility to obtain fingerprinting from an authorized law enforcement agency. Attached is an authorization form which **MUST BE COMPLETED**.

It is imperative that the following blocks be COMPLETELY FILLED OUT.

APPLICANT FINGERPRINT CARD

Name: _____

Height: _____

(Last, First, Middle)

Signature: _____

Weight: _____

Aliases (AKA): _____

Color – Eyes: _____

Citizenship: _____

Color – Hair: _____

Date of Birth: _____

Place of Birth: _____

Race: _____

Social Security Number: _____

Sex: _____

Signature of official taking fingerprints: _____

NEVADA BOARD OF EXAMINERS
FOR
LONG TERM CARE ADMINISTRATORS
3157 N. Rainbow Blvd. #313
Las Vegas, Nevada 89108
Phone: (702) 486-5445
Fax: (702) 486-5439

REGISTRATION APPLICANT ELECTRONIC SUBMISSION FORM

Provide this form to the fingerprint technician at the time fingerprints are taken and return it to BELTCA for inclusion in your application submission.

Applicant Name (Last, First, MI): _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Place of Birth: _____

SSN: _____ Citizenship: _____

Sex: _____ Race: _____ Hgt: _____ Wgt: _____ Eyes: _____ Hair: _____

Reason Fingerprinted: 654.150; 654.155

Registration payment has been confirmed.

ORI: NV920440Z

Account Number: 880351

The above named individual was fingerprinted and said prints
Will be sent electronically to the Central Repository for
Nevada Records of Criminal History on behalf of the
Board of Examiners for Long Term Care Administrators.

Fingerprint Agency Stamp

Fingerprint Representative Signature

TCN#: _____
Date: _____

X. HEALTH STATEMENT

To the best of my knowledge:

- I am of good health and free from contagious disease.
- I do not suffer from any mental impairment that would affect my ability to perform the duties of an administrator.

Applicant's Signature _____ Date: _____

XI. RELEASE OF INFORMATION

Having made application for licensure, I _____ hereby consent to have an investigation as to my moral character, professional reputation, education, experience and other qualifications for licensure as a Residential/Nursing Facility Administrator in the State of Nevada.

I authorize the State of Nevada and its State Board of Examiners for Long Term Care Administrators or their agents or representatives to acquire from any source of information it may request concerning my professional, academic and character qualifications. This information may include, without limitation implied by enumeration, confidential reports, file records, documents and transcripts of any type of civil, criminal, disciplinary, or administrative action or proceedings.

I authorize and request every person, physician, firm, corporation, government agency, or other institution having control of any documents, records, or other information pertaining to me, to furnish such information and to allow review and copying of such information to and by the authorized persons herein.

From time to time, the Board receives requests for mailing lists. These requests generally come from entities that provide CEU courses, and sometimes from facilities in need of an Administrator. Facility information is provided including the name of the administrator. Please indicate below if you would like your personal information (address, phone number and email address) provided on these lists.

I would like my personal information provided for mailing lists: Yes: _____ No: _____

I acknowledge that I am aware of the laws and regulations regarding the licensure of Residential/Nursing Facility Administrators in the State of Nevada.

Applicant's Signature _____ Date: _____

LICENSURE IS MANDATORY IN THE STATE OF NEVADA.

**YOU MAY NOT PRACTICE AS A RESIDENTIAL OR NURSING FACILITY ADMINISTRATOR
UNTIL YOU HAVE FILED AN APPLICATION AND HAVE BEEN GRANTED A
LICENSE IN THE STATE OF NEVADA.**

You must sign this application. Read the following carefully before you sign. A false statement on any part of your application may be grounds for not licensing you, or for denial or revocation of your license. Also, you may be punished by fine or imprisonment (US Code, Title 18, Section 1001):

- * I understand that any information I give may be investigated as allowed by law or Presidential order.
- * I consent to the release of information about my ability and fitness for licensure as a Residential/Nursing Facility Administrator by employers, schools, law enforcement agencies, other organizations, and other authorized individuals.
- * I certify that I will uphold the rules and regulations relative to the responsibilities of an Administrator for Long-Term Care Facilities as required by the State of Nevada.
- * I understand that the requirements for licensure must be completed within a 1-year time limit, or forfeit all fees and training.
- * I certify that, to the best of my knowledge and belief, all of my statements are true, correct, complete, and made in good faith.

Applicant's Signature _____

Date _____