

*****FOR OFFICE USE ONLY*****

Nursing Home Administrator

- App
- Photo ID
- Transcript
- BCI
- 2 Reference Letters
- Curriculum Vitae
- Bachelor's in HCA or
Bachelor's + 15 credit hours
- AIT Field Experience-350 hrs/12 mo

Endorsement

- Out of State Lic. Verification(s)
- Bachelor's + 3 yrs NHA experience in last 5 yrs
- Bachelor's + 3 yrs NHA Mgt in last 5 yrs or
- ACHCA Certificate



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Application Approved:

License Number:

Issue Date:

ID#:

Receipt #:

Instructions and Application For
License As A
Nursing Home Administrator

- By Examination By Endorsement
 (From Another State)

- By American College of Health Care
 Administrators (ACHCA) Certification

MILITARY STATUS ELIGIBILITY

*(Documentation Required)
see next page for instructions*

Please check ONE of the following criteria for expedited application:

- I am in active military duty or a reservist
- I am a military veteran with honorable discharge
- I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

Empty box for Last Name

Empty box for First Name

Empty box for MI

LAST NAME

FIRST NAME

MI

LICENSURE REQUIREMENTS

Please review the following checklists, **choose which one applies to you**, and include all of the required information to complete your Nursing Home Administrator application. There is no fee, however you will be charged a fee at the time of renewal.

By Examination:

1. Proof of 18 years of age - copy of driver's license or state issued id;
2. 2 letters of good moral character;
3. Original BCI check from the RI Attorney General's Office; if positive BCI, a detailed explanation is required.
4. Bachelor's degree in health care administration *OR* Bachelor's degree and completion of 15 credit hours, with a copy of the course description from the accredited college/university catalog, with course title, course number, credit and grade for the required courses.
4. Completion of field experience, 350 hours within a 12 month period, in a Administrator-in-Training (AIT) capacity in a licensed nursing facility;
 - a. Completed AIT Certification form and
 - b. Confirmation of RI nursing facility's nursing home administrator active license.
5. Official school transcript(s), with registrar's signature and school seal;
6. Curriculum Vitae;

Upon completed application, then

7. Completion of written NHA examination, with minimal passing score of 113.

By Endorsement:

1. Proof of 18 years of age - copy of driver's license or state issued id;
2. 2 letters of good moral character;
3. Original BCI check from the RI Attorney General's Office; if positive BCI, a detailed explanation is required.
4. Bachelor's degree *and* 3 years experience as a licensed nursing home administrator, within the most recent 5 years; *OR* Bachelor's degree *and* in a management position with no less than 3 years experience, within the most recent 5 years, having direct responsibility for overseeing and directing 3 or more licensed nursing home administrators:
Provide applicable facility names, addresses, license information along with an attestation from your superior confirming your management position and oversight *OR* Bachelor's degree *and* completion of 15 credit hours, with a copy of the course description from the accredited college/university catalog, with course title, course number, credit and grade for the required courses.
5. Official school transcript(s), with registrar's signature and school seal;
6. Curriculum Vitae;
7. Evidence of a current license in good standing as a NHA in all alternate jurisdictions; (an Interstate Verification form is included in this application for that purpose)

By ACHCA Certification:

1. Proof of 18 years of age - copy of driver's license or state issued id;
2. 2 letters of good moral character;
3. Original BCI check from the RI Attorney General's Office; if positive BCI, a detailed explanation is required.
4. Notarized copy of Certificate from the American College of Health Care Administrators (ACHCA)
5. Official school transcript(s), with registrar's signature and school seal;
6. Curriculum Vitae;
7. Evidence of a current license in good standing as a NHA in all alternate jurisdictions; (an Interstate Verification form is included in this application for that purpose)

Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to check on the status of your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasurer.

I would like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00



State of Rhode Island

Application for License as a Nursing Home Administrator

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Certificate.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."

3. Gender

Male

Female

4. Date of Birth

Month

Day

Year

5. Home Address

It is your responsibility to notify HEALTH of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Home Phone

Home Fax

Email Address

6. Business Address

(ONLY if it is RELATED to your license.)

It is your responsibility to notify HEALTH of all address changes.

This address will appear on the Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Business Phone

Extension

Business Fax

2. Personnel Management

Course Title _____

Course Number _____

College or University _____

Credit and Grade _____

3. Financial Management of Nursing Homes

Course Title _____

Course Number _____

College or University _____

Credit and Grade _____

4. Environmental Management of Nursing Homes

Course Title _____

Course Number _____

College or University _____

Credit and Grade _____

5. Governance and Management of Nursing Homes

Course Title _____

Course Number _____

College or University _____

Credit and Grade _____

Comments: _____

12. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending?

Yes No

Abbreviation of State and Conviction¹ (e.g. CA - Illegal Possession of a Controlled Substance):

Month		Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

13. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined, or are formal charges pending?

Yes No

2. Have you ever been denied a license, certificate, registration or permit in any state?

Yes No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, a separate sheet of paper.

14. Affidavit of Applicant

Complete this section and sign.

I, _____, being first duly sworn, depose and say that I the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Nursing Home Administrator in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform HEALTH of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant _____

Date of Signature (MM/DD/YY) _____



Substitute forms are not acceptable, copy this form as needed.

Rhode Island Department of Health

Room 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

Documentation of Three Hundred Fifty (350) Hours of Field Experience (AIT Certification Form - Required for Examination and Endorsement Applicants Only)

Print/Type Applicant's Full Name _____ Social Security Number _____ Date of Birth _____

R5-45-NHA, "Rules and Regulations for Licensing of Nursing Home Administrators" - Section 3.0, "Qualifications for Licensure" - requires successful completion of a degree in a health-care related field from an accredited College or University and requires satisfactory completion of a field experience of at least three hundred fifty (350) hours, within a twelve (12) month period, in a training capacity in a licensed nursing facility that shall include training in the following areas: Administration, Nursing, Activities Department, Social Services/Admissions, Human Resources, Rehabilitation Department, Medical/Patient Records, Business Office, Dietary Department, Environment/Maintenance and Housekeeping/Laundry. At the conclusion of the field experience, the administrator of the licensed nursing facility where the field experience was performed must attest that the training included each area.

I hereby attest that _____ has satisfactorily completed three hundred fifty (350) hours* of Field Experience in the following areas:

Number of Hours <input type="checkbox"/>	Administration	Number of Hours <input type="checkbox"/>	Nursing	Number of Hours <input type="checkbox"/>	Human Resources
<input type="checkbox"/>	Activities Department	<input type="checkbox"/>	Admissions	<input type="checkbox"/>	Medical/Patient Records
<input type="checkbox"/>	Dietary Department	<input type="checkbox"/>	Environment/Maintenance	<input type="checkbox"/>	Business Office
<input type="checkbox"/>	Rehabilitation Department	<input type="checkbox"/>	Social Services/Admissions	<input type="checkbox"/>	Housekeeping/Laundry
<input type="checkbox"/>	Other, Explain: _____				
<input type="checkbox"/>	Total number of hours in AIT Training Program				

**Hours should be approximate. The weights accorded the six domains of practice per NAB:*

16% Resident Care Management	25% Financial Management	11% Environmental Management
13% Personnel Management	19% Regulatory Management	20% Organizational Management

RI NHA Name _____ RI NHA License Number _____

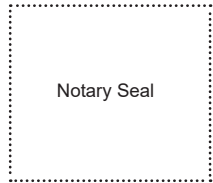
RI NHA Signature _____ Date of Signature (MM/DD/YY) _____

RI Nursing Facility _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp) _____

Signature of Notary _____



Notary No./Commission No. _____

Commission Expiration Date (MM/DD/YY) _____



Substitute forms are not acceptable, copy this form as needed.

Rhode Island Department of Health

Room 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as a Nursing Home Administrator in the State of Rhode Island. The Rhode Island Department of Health requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Department of Health.

_____ Print/Type Full Name	_____ Signature	_____ Date
_____ Previous Names Used	_____ Social Security Number	_____ Date of Birth
_____ License Number	_____ Date Issued	

THIS SECTION TO BE COMPLETED BY THE NURSING HOME ADMINISTRATOR BOARD

Nursing Home Administrator Program Completed:	Location:	Graduation Date:
Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has completed and passed the National Certification Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No	
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

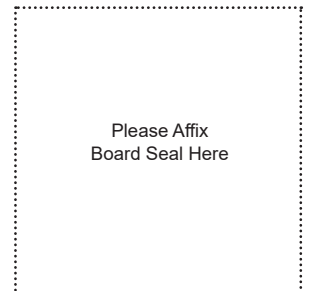
Questions:

- Has this licensee ever been investigated by your Board? Yes No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? Yes No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
- Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

_____ Signature	_____ Date
_____ Type or Print Name	
_____ Title	
_____ Full Name and State of Licensing Board	



Please return directly to HEALTH at the above address. Thank you for your prompt cooperation.