FLORIDA DEPARTMENT OF HEALTH

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Board of Nursing Home Administrators

Name: ____

Last **First** **Middle**

Social Security Number: ___________________________________

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257

PRECEPTOR CERTIFICATION

(Client 801)

PLEASE PRINT OR TYPE IN BLACK INK OR APPLICATION WILL BE RETURNED

Mail To: Board of Nursing Home Administrators
Post Office Box 6330
Tallahassee, Fl 32314-6330
http://www.doh.state.fl.us/mqa/nurshome/index.html
(850) 245-4355

REQUIRED FEES: (Certified Check or Money Order)

Application Fee:	$ 50.00 (non-refundable)
Initial Certification Fee: (3010)	$100.00
Total:	**$150.00**

PROFILE DATA (Please print or type or the application will be returned):

1. **NAME:** ____
(Last) (First) (Middle)

2. **MAILING ADDRESS:** ______________________________________
(Street and Number) (Apt. #) (City) (State) (Zip)

PRIMARY LOCATION: ______________________________________
(Street and Number) (Apt. #) (City) (State) (Zip)

3. **TELEPHONE:** (___)_______________________(___)__________________________
Home: Area Code/Phone Number Work: Area Code/Phone Number

4. **LICENSE NUMBER:** __________

5. **E-MAIL ADDRESS:** ____

6. **LIST ALL SKILLED NURSING FACILITIES WHERE YOU HAVE WORKED FOR THREE (3) OF THE LAST FIVE (5) YEARS:**

____
Beginning/Ending Dates Facility Name, Address, County Facility Rating

____
Beginning/Ending Dates Facility Name, Address, County Facility Rating

____
Beginning/Ending Dates Facility Name, Address, County Facility Rating

7. APPLICANT SIGNATURE:

I, the undersigned, state that I am the person referred to in this application for licensure in the State of Florida.

I state that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.082, 775.083, and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instruments (local, state, federal or foreign) to release to the Department of Health, any information, files and/or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organization, individuals, and groups listed above, any information which is material to my application.

I understand that Florida law requires me, as an applicant for licensure, to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board of Nursing Home Administrators decision concerning my eligibility for licensure. (Section 456.013, Florida Statutes) Failure to do so may result in action by the Board including denial of licensure.

I further state that I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I understand that such action shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida in the profession for which I am applying.

I also state that I will comply with all requirements for licensure renewal in effect at the time of license renewal, including submission of appropriate renewal fees and completion of required continuing education credits.

As a reminder to all applicants, please understand that Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the Department.

____ __________________________________

(Signature of Applicant) (Date)

PRECEPTOR TRAINING COURSE

TO: Florida Board of Nursing Home Administrators
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257

FROM: ____
(Please type or print)

____

I have completed the six (6) hour preceptor training course in compliance with Rule 64B10-16.0025, Florida Administrative Code. **Attached a copy of the certificate of completion.**

Course Completion Date: ___________________

Instructor: ______________________________

Sponsored by: __________________________

Have you previously been approved as a Florida preceptor? _____ No _____ Yes

I declare that these statements are true and correct and recognize that providing false information may result in a fine, suspension or revocation of my license as provided in Florida Statutes 456.067, 755.082 or 755.084.

____
Signature (Required)

____
Date (of signature)