

DEPARTMENT OF HEALTH
BOARD OF NURSING HOME ADMINISTRATORS
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257
850/245-4355

**APPLICATION INSTRUCTIONS
FOR RE-EXAMINATION**

*** PLEASE TYPE OR PRINT IN BLACK INK ***
PLEASE READ CAREFULLY

NOTE: Applications are accepted on a continuous basis, there are no deadlines.

1. FLORIDA LAWS & RULES: A copy of Section 468, Part II, Florida Statutes and Rule Chapter 64B10, Florida Administrative Code are available by downloading them at <http://www.doh.state.fl.us/mqa/nurshome/index.html> This information is also available over the internet via our web site. It is important to read this in order to determine your eligibility prior to applying, and to familiarize yourself with the statutes and board rules regarding your application for licensure as a nursing home administrator.

2. APPLICANT'S QUESTIONS REGARDING APPLICATION STATUS: Within thirty (30) days after the board office receives your application and fee, we will send an acknowledgment letter informing you of any deficiencies and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date mailed, please contact this office. As a reminder to all applicants, Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after initial filing with the department.

3. EXAMINATION INFORMATION: The Florida Nursing Home Administrators Examination consists of two parts; one being the NHA examination and the other being the Florida Laws and Rules examination. The NHA examination is developed and administered by the National Association of Board of Examiners of Nursing Home Administrators. Upon board approval, you must submit your application through NAB's CDOM system at their website nabweb.org in order to be scheduled. The NAB CDOM will provide an email response informing you of your eligibility along with your authorization to test letter. You will be provided the toll-free number for use in scheduling your exam, a list of testing centers and appropriate online scheduling instructions. The Florida Laws and Rules examination is developed by the Florida Department of Health and administered by the contracted vendor. Please download the Candidate Information Booklet (CIB) for this examination from the Testing Services website at <http://www.doh.state.fl.us/mqa/Exam/schedule-nha.htm> Both exams are given on a continued basis. Please allow 30 days after you receive the on-site results for the Department to process your official grade results. For any information on examination scheduling and associated fees, please contact NAB.

4. REVIEW AND STUDY COURSES: The following organization offers a review or study course for the nursing home administrator licensure examination NAB. Please be advised the Board of Nursing Home Administrators is not recommending this course, but simply stating this as a courtesy to the sponsor. To receive additional information on dates and times the review is given, please contact the provider directly: Professional Health Care Education Systems, Inc., Post Office Box 291883, Tampa, Florida 33617, Attention: Inez Joseph, Ph.D., Phone (813) 982-1554.

5. RETAKE APPLICANTS: Applicants who are retaking either examination should log on to the NAB website for the National Examination and/or Prometric for the Florida Laws and Rules Examination. You **MUST** submit a new complete application, with one photo and reexamination fees. Retake applicants are **NOT** required to resubmit transcripts or any other documentation previously provided; however, licensure verifications must be resubmitted. You are allowed to retake the examination four times within a 12-month period from the date of your initial application. You must wait 30 days after failure of each examination to retake.

6. YES/NO QUESTIONS: All questions with a "Yes or No" answer must be marked with either a "Yes or No" no other response is acceptable. In questions which require a brief explanation or description to "Yes" answers, your responses must be sufficiently detailed to ascertain the relevant dates, institution/organization names, and a brief synopsis of the reasons (i.e., the final charges or substantiated allegations) the institution/organization took the disciplinary action (i.e., probation, limitation, suspension, revocation, voluntary relinquishment in lieu of disciplinary action, or any other adverse action). However, if a question contained in this survey is not applicable answer "NA" in the column. Certified documentation of final disposition to "yes" answers is required.

7. ADDITIONAL SPACE NOTE: Should any of the sections in the application fail to provide sufficient space for the requested information, use an additional page or the reverse side of the application page on which the question is located. Always number the additional information with the corresponding number in the application.

8. FEDERAL PRIVACY ACT: Under the Federal Privacy Act, disclosure of social security numbers is voluntary unless specifically required by federal statute. In this instance, social security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and sections 456.013, 409.257(7) and 409.259(8), F. S. Social security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D

child support agency to assure compliance with child support obligations. Social security numbers must also be recorded on all professional and occupational license applications and will be used for license verification pursuant to, unless exempt as outlined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

Note: If you do not fill in your social security number, your application may be delayed.

SUPPORTING DOCUMENTS - THE FOLLOWING ITEMS MUST BE INCLUDED WITH YOUR APPLICATION:

1. One Photograph: Write your name on the back of the "passport type" (i.e., full-face) photograph and staple it to the bottom right side of the first page of the application. The photograph should be approximately 2" by 2" and be a clearly recognizable picture of your full-face, taken within the last six months.

2. Fee Schedule: A certified check or money order in the appropriate amount, made payable to the Department of Health, must be attached to your application. Please staple the certified check or money order to page 1 of the application on the upper left part of the form. Your application will not be processed without these fees. These fees are required by law and include the following:

Re-examination:

Examination Fee	\$ 250.00
Department Administrative Costs*	\$ 335.00
Total Fee	\$ 585.00

*See Rule [64B-1.016](#) **Fees: Examination and Post-Examination Review** – The fees cover administrative costs, actual per-applicant costs, and costs incurred to develop, purchase, validate, administer, and defend department developed, administered, or managed examinations.

3. Official Licensure Verification: The licensure verification forms included with this application package must be sent to each state or other licensing authority where you currently hold or have held a license to practice, regardless of the status of the license. These forms must be sent directly from each state licensing agency to this office. Please note that it is your responsibility to follow-up with licensing agencies to ensure that they have received and complied with your requests. The board office will notify you as items are received. **A copy of your license will not be accepted in lieu of official verification from the licensing agency.**

4. Request for an Application for Special Testing Accommodations: You must complete this form and mail it to the address shown on the bottom of the application. This form does not constitute an application for special testing accommodations. The Department will mail you an application to be completed and returned back to the Bureau of Operations, Testing Services.

YOUR APPLICATION IS NOT CONSIDERED COMPLETE UNTIL ALL SUPPORTING DOCUMENTS AND FEES HAVE BEEN RECEIVED BY THIS OFFICE.



CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health Board of Nursing Home Administrators

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 USCA § 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), and (12), Florida Statutes.

Name: _____
 Last **First** **Middle**

Social Security Number: _____

APPLICANT HISTORY: (If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)

1. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [] YES [] NO
2. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? [] YES [] NO
3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice as a nursing home administrator within the past five years? [] YES [] NO
4. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice as a nursing home administrator? [] YES [] NO
5. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? [] YES [] NO
6. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice as a nursing home administrator within the last five years? [] YES [] NO

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



**APPLICATION FOR NURSING HOME ADMINISTRATORS
RE-EXAMINATION (Client 801)**

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

APPLICATION CATEGORY:

RE-EXAMINATION (1011) \$585.00 NAB Florida Laws & Rules

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

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

a. Have you changed your name through marriage or through action of a court, or have you been known by any other name?
 Yes No

If yes, list name(s) (Last, First, Middle) and Date(s) of changes

2. a. **MAILING ADDRESS:** _____
(Street and Number) (Apt. Number)

(City) (State) (Zip)

b. **PRACTICE LOCATION:** _____
(Street and Number) (Apt. Number)

(City) (State) (Zip)

3. **TELEPHONE:** (____) _____ (____) _____
Home: Area Code/Phone Number Work: Area Code/Phone Number

4. PERSONAL DATA:

a. Date of Birth: _____ b. Place of Birth: _____
(Month/Day/Year)

c. Email Address: _____ d. U.S. Citizen: Yes No

e. We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian African-American/Black Hispanic Asian Native American Other
SEX: Male Female

f. Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes No

**Staple Photo
DO NOT GLUE
PASTE OR TAPE**

NAME: _____

5. APPLICANT HISTORY – GENERAL (ATTACH ADDITIONAL SHEETS IF NECESSARY)

a. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction, or have you ever been a defendant in a military court-martial? (Do not include parking or speeding violations) YES NO

If YES, please list date, jurisdiction (state and county), offense, disposition, and all other related information on attached sheets. Certified copies of court disposition must be provided.

b. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for the purposes of this question. YES NO

If YES, please list date, jurisdiction (state and county), offense, disposition, and all other related information on attached sheets. Certified copies of court disposition must be provided.

c. Have you ever been declared legally incompetent? YES NO

If YES, please explain in full on attached sheets as to court date and circumstance and medical practitioners consulted.

d. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances? YES NO

Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

e. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? YES NO (If no, do not answer f.)

f. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? YES NO

g. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? YES NO (If no, do not answer h.)

h. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? YES NO

i. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? YES NO (If no, do not answer j. and k.)

j. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? YES NO

k. Did the termination occur at least 20 years prior to the date of this application? YES NO

6. APPLICANT HISTORY – PROFESSIONAL LICENSURE (ATTACH ADDITIONAL SHEETS IF NECESSARY)

Certified documentation of final disposition to “yes” answers is required.

a. Do you now hold or have you ever held a license or certificate or registration to practice nursing home administration in any state, U.S. territory or foreign country? YES NO If yes, please list all licenses below.

State and License #	Date of Original License	If license is not now in force, how and when validity ceased
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NAME: _____

b. Do you now hold or have you ever held a license or certificate or registration to practice any other regulated profession in any state, U.S. territory or foreign country? YES NO If yes, please list all licenses below.

State and License #	Date of Original License	If license is not now in force, how and when validity ceased

c. Have you ever been denied the right to take a Nursing Home Administrator examination in any state? YES NO

d. Have you ever been refused a license to practice Nursing Home Administration or any other license or the renewal thereof in any state? YES NO

e. Have you ever had a license or certificate of registration to practice as a Nursing Home Administrator or any other licensed profession revoked, suspended, surrendered or otherwise acted against (including probation, fine, reprimand or surrender of licensed) in a disciplinary proceeding in any state? YES NO

f. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge or violation of the nursing home administrator practice act, unprofessional or unethical conduct? YES NO

g. Have you ever been a defendant in civil litigation in which the basis of the complaint against you was an alleged negligence, malpractice, or lack of professional competence? YES NO

h. Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including:

- | | |
|--|--|
| 1. Acts of dishonesty, fraud, or deceit | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Academic misconduct, including acts such as cheating | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Lying on a resume or misrepresentation | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. Misconduct involving student activities | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 5. Theft | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6. Actions in disregard of the health, wealth and safety of others | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 7. Sexual harassment | <input type="checkbox"/> YES <input type="checkbox"/> NO |

i. Have you ever had employment terminated for cause? YES NO

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.

APPLICANT SIGN HERE: _____ DATE: _____



CANDIDATE REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities Act, please **submit to Professional Examination Service, this completed form and attach the appropriate documentation as indicated in the Candidate Handbook** so your accommodations for testing can be processed efficiently. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

Applicant Information

Last Name	First Name	Middle Name
Address (line 1)		
Address (line 2)		
City	State	Zip Code
Jurisdiction in which you have applied for licensure		

Special Accommodations - I request special accommodations for the administration of the:
(Please check each examination that applies to you.)

- Nursing Home Administrators Licensing Exam (NHA)
- State-Based Laws & Regulations Exam (NSBL)

Please provide (check all that apply):

_____	Accessible testing site
_____	Special seating
_____	Large print test (specify point size) _____
_____	Reader
_____	Circle answers in test booklet
_____	Extended testing time (time and a half)
_____	Separate testing area
_____	Other special accommodations (please specify)

Send original documents to:
Professional Examination Service
Attention: NAB Program Director (644)
475 Riverside Drive, 6th Floor
New York, NY 10115-0089

Send copies to:
State Board/Agency in which you are
making application for licensure