



GEORGIA STATE BOARD OF NURSING HOME ADMINISTRATORS
237 Coliseum Drive * Macon, Georgia 31217
Phone (478) 207-2440
www.sos.state.ga.us/plb/nursinghome

APPLICATION FOR NURSING HOME ADMINISTRATOR BY RECIPROCITY

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Nursing Home Administrators in the State of Georgia. Visit the web site for information.

“IMPORTANT”

The Board will not process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all required information and documentation is complete and correct. An incomplete application will result in delayed processing. Incomplete applications are void after one year and will result in a new application and fee.

Application Checklist

The following checklist is an important part of your application. Please use this checklist to ensure that you submit a **COMPLETE** application.

The \$200.00 **NON-REFUNDABLE** application fee payable to Georgia State Board of Nursing Home Administrators **MUST** be included with application.

Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.

- NOTARIZED APPLICATION:** mail the signed, notarized application and required fee to the Board's office at the address listed above. All questions must be answered. Any question answered “yes”, requires further documentation to be submitted. Attach a copy of all charges and the disposition if you have had any criminal convictions or charges or sanctions by another state licensing board.
- SECURE AND VERIFIABLE DOCUMENT – all applicants must submit a secure and verifiable document, as defined in Code Section 50-36-2. See list of acceptable document son the website www.sos.ga.gov/plb.**
- AFFIDAVIT OF CITIZENSHIP** – Page 6 of this application
- APPROVED STATE:** Applicants from the approved states list must send the application, fee, affidavit of applicant and verification from every state licensed.
- NON-APPROVED STATE:** Applicants from the non-approved states listed below must send the application, fee, affidavit of experience for one year as a licensed administrator, affidavit of applicant, twenty hours (20) of Continuing Education hours obtained within one year of date on this application, official NAB score and verification from every state licensed.

NHA APPROVED STATES FOR ENDORSEMENT

PLEASE SEND THE APPLICATION, FEE, AFFIDAVIT OF APPLICANT AND STATE LICENSURE VERIFICATION. MUST BE AT LEAST 21 YEARS OF AGE.

ALABAMA	NEW JERSEY
ARIZONA	NEW MEXICO
ARKANSAS	NEW YORK
CALIFORNIA	NORTH DAKOTA
CONNECTICUT	NORTH CAROLINA
DELAWARE	OHIO
FLORIDA	OREGON
IDAHO	PENNSYLVANIA
INDIANA	RHODE ISLAND
IOWA	SOUTH CAROLINA
KANSAS	SOUTH DAKOTA
MAINE	TEXAS
MARYLAND	UTAH
MASSACHUSETTS	VERMONT
MINNESOTA	VIRGINIA
NEBRASKA	WASHINGTON DC
NEW HAMPSHIRE	WEST VIRGINIA
	WYOMING

NON-APPROVED STATES FOR ENDORSEMENT

PLEASE SEND APPLICATION, FEE, AFFIDAVIT OF EXPERIENCE FOR ONE YEAR AS LICENSED ADMINISTRATOR, AFFIDAVIT OF APPLICANT, TWENTY (20) HOURS OF CEUS WITHIN ONE YEAR OF DATE ON APPLICATION AND STATE BOARD LICENSURE VERIFICATION (HAVE NO BOARD SANCTIONS) WITH PASSING NAB EXAM SCORES, AND BE AT LEAST 21 YEARS OF AGE.

ALASKA	MISSOURI
COLORADO	MONTANA
HAWAII	NEVADA
ILLINOIS	OKLAHOMA
KENTUCKY	TENNESSEE
LOUISIANA	WASHINGTON
MICHIGAN	WISCONSIN
MISSISSIPPI	

FOR BOARD USE ONLY
 Amount Submitted _____
 Date _____
 Receipt # _____



FOR BOARD USE ONLY
 Certificate Number _____
 Date Issued _____
 Applicant No. _____

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**APPLICATION FOR LICENSURE AS A NURSING HOME ADMINISTRATOR
 BY RECIPROCITY**

Application Fee \$200.00 (non-refundable)
Checks returned for insufficient funds will be assessed a service charge pursuant to
O.C.G.A. §16-9-20.

Method Obtained by: Applicant is applying for above referenced license by:
 Applicant from the APPROVED STATE LIST
 Applicant from the NON-APPROVED STATE LIST

PART I – PERSONAL INFORMATION

Name: _____
 (As desired on License) Last First Middle

Name as shown on exam records or transcripts (If different):

 Last First Middle
 ____/____/____ Sex: ___ M ___ F ____/____/____
 *Social Security Number Date of Birth

**This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A.1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes*

Physical Address: _____
 (P.O. Box **not** acceptable) Number and Street Apt. No City/State Zip

If you are granted a license, your name, mailing address and license number are public information and your mailing address will appear on the internet. Your physical address is required, if different than the mailing address. You must immediately notify the Board in writing of an address change.

Mailing Address: _____
 (if different-PO Box Acceptable) Number and Street Apt. No City/State Zip

 Telephone Number (Day) Telephone Number (Evening) Cell Phone

E Mail Address: _____
 (Please print clearly)

PART II – EDUCATION

- Please submit the following:
 - Copy of High School Diploma Official College Transcript(s) (either mailed directly from university to the Board, or include with your application documents, showing degree and date awarded)
- **Please indicate below:**

High School	City/State	Dates Attended	Degree
University/College			

PART III – PROFESSIONAL BACKGROUND

Instructions: If you answer yes to any of the following questions, attach an explanation, relevant documents and copy of final disposition indicating a description of the current status. For the purpose of the following questions, the terms “licensee,” “registration,” and “certification” are synonymous.

- Yes No Have you had revoked or suspended or otherwise sanctioned any license issued to you by any board or agency in Georgia or any other State?
- Yes No Were you denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a of a license or the privilege of taking an examination by any state licensing board?
- Yes No Have you knowingly failed to renew a license during an investigation of disciplinary action?
- Yes No Have you been subject to disciplinary action or had your membership revoked by a professional organization governing the practice of that profession?
- Yes No Are you currently unable to practice with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, chemicals or any other type of material, or as a result of any mental or physical condition?
- Yes No Have you had any suit filed against you related to the practice of a profession?
- Yes No Have you ever had your Medicaid and/or Medicare privileges revoked or restricted?
- Yes No Have you ever been arrested or convicted of a felony, misdemeanor (other than a minor traffic violation), crime involving moral turpitude, or a crime violating federal or state law relating to controlled substances or dangerous drugs? (DWI and DUI are not minor traffic violations.) For purposes of this question, a “conviction” includes a finding of verdict of guilty, plea of guilty, a plea of nolo contendere, or first offender treatment, and also includes adjudication of guilt or sentence withheld or not entered on the charge (s). NOTE: The answer to this question is “YES” if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled & completed probation under First offender and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record.

If “yes,” please include a certified copy of the court records and final disposition from the court with your application. In the event the file no longer exists, you must submit documentation from the court stating that fact. Also include a personal letter of explanation regarding each incident, and the Background Investigation Consent Form (print out and complete, submit with the application).

- Please complete the following if you have ever held a professional license in another profession:

License Title _____ State _____

Date Issued _____ Expiration Date _____

License Title _____ State _____

Date Issued _____ Expiration Date _____

PART IV – EMPLOYMENT

- Please complete the following information concerning your current employment:

Company Name _____

Type of Facility _____ Current Position _____

Address _____
Street Ste # City State Zip Code

Phone Number: () _____ Fax Number _____

Dates of Employment: From _____ To _____ Total Time Worked _____

Hours per week _____ Type of Employment: Full Time _____ Part Time _____

PART V – RECIPROCITY

Please list all states in which you have held a Nursing Home Administrator License (contact state for official verification of license, must be mailed directly to Georgia Board with state seal)

State Issued _____ Date Issued _____ Expiration Date _____

State Issued _____ Date Issued _____ Expiration Date _____

State Issued _____ Date Issued _____ Expiration Date _____

Have you successfully passed the National Association of Boards of Examiners (NAB) licensing exam?
 _____ Yes _____ No

Affidavit Regarding Citizenship

Print Name: _____

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Board for which I am applying for licensure and I agree to abide by these laws and rules.

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, administered by the Professional Licensing Boards Division, the undersigned applicant also verifies one of the following with respect to his/her application for a public benefit (check one):

1) _____ I am a United States citizen. **Please ATTACH a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or document as indicated on the Board website, www.sos.ga.gov/plb, with this application.**

2) _____ I am **not** a United States citizen, but I am either a legal permanent resident of the United States or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number (See Board website www.sos.ga.gov/plb, with this application.**

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

In making the above representations under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute. I also understand that any failure to make full and accurate disclosures may result in disciplinary action by the Board for which I am applying for licensure.

Executed in _____ (City), _____ (State)

Signature of Applicant _____

Printed Name of Applicant _____

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE

DAY OF _____, 20_____

Notary Seal

Notary Public

My Commission Expires _____

Nursing Home Administrator * Affidavit of Applicant

Please document with your initials that you have reviewed each of the resources listed below. Have the Affidavit notarized and return to the NHA Board, 237 Coliseum Drive, Macon, Georgia 31217-3858.

_____ Department of Community Health, Division of Medical Assistance, Part I Policies and Procedures; Part II Policies and Procedures Applicable to Nursing Facility Services (Chapter 600-1100 and Appendices) www.ghp.georgia.gov Click provider information at top of page. Click Medicaid Provider manuals. Click Health Services Check.

_____ Georgia State Board of Nursing Home Administrators Law (OCGA 43-27-11)

_____ Georgia statutes regarding Living Will, Durable Power of Attorney for Health Care, Withholding or withdrawal of life-sustaining procedures (OCGA Section 31)

_____ Determination of residences of decedent in care of nursing home at time of death (OCGA 53-1-5)

_____ Fire Safety Codes (OCGA 25-2-13{d, e and f})

_____ OCGA Title 31 pertaining to Department of Human Resources with particular attention to sections pertaining to Long Term Care Facilities

OFFICIAL CODE OF GEORGIA ANNOTATED (OCGA)

All statutory requirements are accessible via

<http://ors.dhr.georgia.gov/portal/site> go to Services, to Long Term Care, to Current, to Long Term Care, to Skilled Nursing Home. You may type in the additional chapters under search.

_____ Nursing Homes (Chapter 290-5-8)

_____ Food Service (Chapter 290-5-14)

_____ Long Term Care Facilities: Residents Bill of Rights (Chapter 290-5-39)

_____ Disaster Preparation Plans (Chapter 290-5-45)

_____ Georgia Rules for Nursing Home Administrators
(www.sos.state.ga.us/plb/nursinghome) Board Rules

Date: _____ (Printed) Name of Applicant: _____
(Signature of Applicant)

Sworn to and subscribed before me this
____ day of _____, 20____,

Signature of Notary Public _____

My commission expires _____

Notary Seal



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This form must be submitted as proof of (1) one year experience as a licensed administrator, as stated in Board Rule 393-9-.02 only if you are licensed in a Non-approved State.

AFFIDAVIT OF EXPERIENCE

FORM A

- Please type or print legibly
- Complete a form for each employer in order to meet the required experience for your application
- Applicant **completes Part I**
- Owner/Administrator of the nursing facility or the employer/superior in the chain of command at the home office that operates the licensed nursing facility and/or hospital **completes Part II**

PART I – APPLICANT

Applicant's Name _____

Name of business or corporation that owns facility:

Name of facility _____

Address of facility _____
Street City State Zip

Phone number of facility _____ **Position held** _____

Dates employed: From: _____ **To:** _____
Month/Year Month/Year

Description of Responsibilities:

Affidavit

I, the above Applicant, attest that the above information is a true and accurate representation of experience obtained in a nursing facility or home office that operates licensed nursing facilities or hospitals.

Date

Signature of Applicant

