



GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS  
237 Coliseum Drive, Macon, Georgia 31217  
Phone 404-424-9966  
[www.sos.ga.gov](http://www.sos.ga.gov)

**APPLICATION FOR NURSING HOME ADMINISTRATOR BY RECIPROCITY FOR  
HEALTH SERVICES EXECUTIVE (HSE)**

*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.

Please use this checklist to ensure that you submit a **COMPLETE** application.

- ☐ **\$200.00 Application Fee + \$10.00 processing fee:** this is non-refundable and should be made payable to the Georgia State Board of Long-Term Care Facility Administrators. This **MUST** be included with the application. Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.
- ☐ **Health Services Executive Qualification:** This application is specifically for applicants who are licensed as a Nursing Home Administrator in another state and hold a Health Services Executive (HSE) qualification from the National Association of Long Term Care Administrator Boards (NAB). You must transfer your HSE Application to this jurisdiction through NAB.
- ☐ **Notarized Application:** mail the signed, notarized application to the Board's office at the address listed above. All questions must be answered. Any question answered "yes" in the "Professional Background" portion of the application requires further documentation to be submitted, including a certified copy of the official documents showing the final disposition of the incident as well as a personal, detailed letter of explanation regarding each incident.
- ☐ **Secure and Verifiable Document:** all applicants must submit a secure and verifiable document, as defined in Code Section 50-36-2.
- ☐ **Affidavit of Citizenship** (Page 5 of this application)

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 FOR HEALTH SERVICES EXECUTIVE**

**Application Fee \$200.00 + \$10.00 processing fee (non-refundable)**

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

**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. # 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-P.O. Box Acceptable) Number and Street Apt. # City/State Zip

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Telephone Number (Day) Telephone Number (Evening) Cell Phone

E Mail Address: \_\_\_\_\_  
 (Please print clearly)

☐ Please check this box if you are a military spouse or a transitioning service member of the United States armed forces (including the National Guard).

## PART II – PROFESSIONAL BACKGROUND

**Instructions:** If you answer “Yes” to any of the following questions you are required to provide a certified copy of the official documents showing the final disposition of the incident as well as a personal, detailed letter of explanation regarding each incident. In the event the file no longer exists, you must submit documentation, from the court or appropriate agency, stating that fact. To avoid processing delays please submit all documentation as part of your application packet. For the purpose of the following questions, the terms “licensee,” “registration,” and “certification” are synonymous.

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 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? **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.  
\_\_\_\_ Yes \_\_\_\_ No

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 III – 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  
\*Please request a score report from NAB be sent/transferred to the Georgia NHA Board

## **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](http://www.sos.ga.gov), 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](http://www.sos.ga.gov)), 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 \_\_\_\_\_

Georgia State Board of Long-Term Care Facility Administrators  
Affidavit of Applicant

*Please document with your initials that you have reviewed each of the resources listed below and have the affidavit notarized.*

All statutory requirements are accessible via: <http://www.lexisnexis.com/hottopics/gacode/Default.asp>

All Rules and Regulations are accessible via: <http://rules.sos.ga.gov/>

\_\_\_\_\_ Department of Community Health, Division of Medical Assistance, Nursing Facility Services Policy Manual - from <https://www.mmis.georgia.gov/portal/default.aspx> select “Provider Manuals” under the “Provider Information” tab.

\_\_\_\_\_ Georgia State Board of Long-Term Care Facility Administrators Law (OCGA § 43-27)

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

\_\_\_\_\_ Georgia statutes pertaining to Department of Community Health with particular attention to sections pertaining to Long Term Care Facilities (OCGA § 31)

\_\_\_\_\_ Fire Safety Codes (OCGA § 25-2-13)

\_\_\_\_\_ Disaster Preparedness Plans (Chapter 111-8-16)

\_\_\_\_\_ DHS Rules pertaining to Nursing Homes/Long-Term Care Facilities (290).

\_\_\_\_\_ Board Rules pertaining to Long-Term Care Facility Administrators (393).

\_\_\_\_\_  
(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*



Georgia State Board of Long-Term Care Facility Administrators  
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**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

**PART II – OWNER/ADMINISTRATOR/EMPLOYER/SUPERIOR**

**Instructions**

- Please review the applicant's description of experience
- Please submit comments or any additional information that will assist the Board in its decision regarding licensure for the applicant:

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, the undersigned \_\_\_\_\_ Owner/Administrator of the nursing facility, or \_\_\_\_\_ Employer or Superior in the chain of command at the home office that operates licensed nursing facilities and/or hospitals, attest that the description provided by the Applicant of the experience obtained in a nursing facility, home office of a business or corporation that operates licensed nursing facilities or hospitals, is true and accurate, and I further acknowledge that I may be required to furnish additional information promptly for this application to be processed.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Nursing Home Administrator/Employer

\_\_\_\_\_  
Signature of Nursing Home Administrator/Employer

**Subscribed and sworn to before me this**

\_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
**Notary Public**

**My Commission Expires** \_\_\_\_\_

*Notary Seal*



**Office of the Secretary of State**  
**Name-Based Criminal History Record Information Consent/Inquiry Form**

I hereby authorize the Georgia State Board of Long-Term Care Facility Administrators to conduct  
Agency/Company  
an inquiry for the purpose listed below and receive any Georgia and/or national criminal history record information as  
authorized by state and federal law.

Full Name (print)			
Address			
Sex	Race	Date of Birth	Social Security Number

**Please check ONLY one of the boxes listed below:**

- ☐ This authorization is valid for \_\_\_\_\_ days from date of signature.
- ☐ I, \_\_\_\_\_, give consent to the above-named  
entity to perform periodic criminal history background checks for the duration of my employment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**AREA BELOW IS FOR AGENCY USE ONLY**

Date of Inquiry: \_\_\_\_\_ Time of Inquiry: \_\_\_\_\_ Operator's Initials: \_\_\_\_\_

Purpose Code Used: (check one)

NON-CRIMINAL JUSTICE PURPOSES	
<input type="checkbox"/>	E - Employment
<input type="checkbox"/>	M - Working with Mentally Disabled
<input type="checkbox"/>	N - Working with Elderly
<input type="checkbox"/>	W - Working with Children
<input type="checkbox"/>	P - Public Records (no consent required)
<input type="checkbox"/>	F - Probate Court / Weapons Carry License
PERSONAL REQUEST (INDIVIDUAL OR THEIR ATTORNEY)	
<input type="checkbox"/>	U - Personal Copy
CRIMINAL JUSTICE	
<input type="checkbox"/>	J - Civilian Criminal Justice Employment (State & III Info Received)
<input type="checkbox"/>	Z - Sworn Criminal Justice Employment (State & III Info Received)

The inquiry resulted in the following: (check all that apply)

<input type="checkbox"/>	No Criminal Record Available
<input type="checkbox"/>	Criminal Record (Attached/Released)
<input type="checkbox"/>	No NCIC/GCIC Warrant
<input type="checkbox"/>	Possible NCIC/GCIC Warrant (List Wanting Agency Below)

Wanting Agency Name: \_\_\_\_\_

Wanting Agency Telephone: \_\_\_\_\_

Agency Designee Signature and Title: \_\_\_\_\_ Date: \_\_\_\_\_