



GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS
237 Coliseum Drive, Macon, Georgia 31217
Phone 404-424-9966
www.sos.ga.gov/plb

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.

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.
- 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. _____

GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS
237 Coliseum Drive • Macon, Georgia 31217 • 404-424-9966
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**APPLICATION FOR LICENSURE AS A NURSING HOME ADMINISTRATOR
 BY RECIPROCITY**

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 – EDUCATION

- Please submit the following:
Copy of High School Diploma or 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 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 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 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 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/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 _____

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



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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



**Georgia Bureau of Investigation
Georgia Crime Information Center**

CONSENT FORM

I hereby authorize **The Georgia State Board of Long-Term Care Facility Administrators** to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

Full Name (Print)

Address, City, State, County, Zip

Sex

Race

Date of Birth

Social Security Number

By signing this form, I acknowledge that I have been informed of the Non-Criminal Justice applicant's Privacy Rights and the Privacy Act Statement (title 28 United States Code § 534).

Signature

Date

Special employment provisions (check if applicable):

- Employment with mentally disabled (Purpose code "M")
 Employment with elder care (Purpose code "N")
 Employment with children (Purpose code "W")

Select one of the following (required):

This authorization is valid for 90 days / 180 days / days from date of signature.

I, _____, give consent to the above named to perform periodic criminal history background checks for the duration of my employment with this company.