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 TO REQUEST INACTIVE STATUS
OF A LONG-TERM CARE FACILITY ADMINISTRATOR LICENSE

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Long-Term Care Facility 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 **non-refundable $100.00** application fee + **$10.00** processing fee payable to **Georgia State Board of Long-Term Care Facility 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: the application must be signed, notarized, include the FEE and mailed to the Board's office at the address listed above.

NOTE: If you choose to request your license be returned to Active status, please apply to the Board using the "Application to Request Active Status" and follow the instructions.

FOR BOARD USE ONLY		FOR BOARD USE ONLY
Amount Submitted _____		Certificate Number _____
Date _____		Date Issued _____
Receipt # _____		Applicant No. _____

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Application Fee $100.00 + $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 of licensee: _____
Last First Middle Maiden

_____ _____ _____
***Social Security Number** **Date of Birth** **License Number**

*****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) **Number and Street Apt. No City/State Zip**

_____ _____ _____
Telephone # (Day) **Telephone # (Evening)** **E-Mail Address**

_____**I am a U.S. citizen.** _____**I am not a U.S. citizen, but am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the U.S.**

PART II – AFFIDAVIT

I hereby attest that I am not practicing nor do I intend to practice as a Long-Term Care Facility Administrator in Georgia, until such time as I have requested and been approved by the Board to reactivate my license to a current valid status.

_____ Date: _____
(**Signature of Licensee)**

Sworn to and subscribed before me this _____
(**Signature of Notary Public)**

_____Day of_____, 20_____. _____
(My Commission Expires) *Notary Seal*