



GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS
237 Coliseum Drive * Macon, Georgia 31217-3858
Phone 404-424-9966
www.sos.ga.gov/plb

**APPLICATION TO REQUEST ACTIVE STATUS
OF INACTIVE 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** \$200.00 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 mailed to the Board's office at the address listed above, along with your **FEE**. All questions must be answered. Any question answered "yes" requires further documentation to be submitted. Attach copies of official court documents and an explanation if you have had any criminal convictions or charges, or sanctions by another state licensing board. Approval of licensure is at the Board's discretion.
- CONTINUING EDUCATION:** If inactive 12 months or less, but not more than 24 months, submit 40 hours of CE obtained since the last active renewal period. If inactive 24 months, but less than 36 months, submit 80 hours of CE obtained since the last active renewal period. If inactive more than 36 months, meet current requirements and either submit 80 hours of CE obtained since the Boards last renewal period, **OR**, take and pass national exam.

NOTE: If the inactive licensee holds an active license in another state, and has been actively employed for one year as a Long-Term Care Facility Administrator prior to the date of submitting this "Reactivation" application, then the applicant should submit the application, the fee, and verification of an active, current license from the approved state or jurisdiction in which the license is held.

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



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

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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 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

PART II – PROFESSIONAL CERTIFICATIONS

Please list any license you may hold in another profession or if you have held/hold a Long-Term Care Facility Administrator License in another state:

State _____ Issue date _____ Expiration Date _____

State _____ Issue date _____ Expiration Date _____

State _____ Issue date _____ Expiration Date _____

***Note: If you have had any type of disciplinary action taken with another licensing agency, please request a copy of Board’s final disposition of action. *See background – Part V**

PART III – CONTINUING EDUCATION

I attest that I have completed/met all of continuing education requirements for the years my license has been inactive, as the Board’s CE rule requires. **You must submit copies of all CE certificates showing hours obtained.**

_____ (Signature of Applicant)

PART IV – PROFESSIONAL BACKGROUND

Instructions: If you answer yes to any of the following questions, attach an explanation, relevant documents and 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 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 To the best of your knowledge, is there any disciplinary action pending against you by any licensing board or professional organization?
- 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 restricted or revoked?
- 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.*

PART V –EMPLOYMENT

WORK EXPERIENCE: (*Note: Applicant must indicate last type of work experience since license was placed on “inactive status”- List additional work experience on a separate page)

Name of Facility _____ Job title _____

Facility Address _____
Street City State Zip

Employment Dates: From _____ To _____

Duties _____

PART VI – AFFIDAVIT

YOU MUST SIGN THIS AFFIDAVIT IN THE PRESENCE OF A NOTARY

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 Georgia State Board of Long-Term Care Facility Administrators, and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) _____ I am a United States citizen 18 years of age or older. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver’s license or passport. See full list of approved documents at www.sos.ga.gov/plb.**

2) _____ I am **not** a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older 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.**

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia State Board of Long-Term Care Facility Administrators and/or criminal prosecution.

_____ Signature of Applicant

_____ Date

Sworn to and subscribed before me this

_____ day of _____ 20_____

(Notary Seal)

_____ Notary Public Signature

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 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.