



2514) 001 - \$450.00
2514) 006 - \$ 10.00
\$460.00

TENNESSEE BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS

665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
LOCAL (615) 741-3807
TOLL FREE 1-800-778-4123 ext.7413807
www.tennessee.gov/health

APPLICATION FOR LICENSE AS A NURSING HOME ADMINISTRATOR

INSTRUCTIONS

1. Complete this application, have it notarized, enclose a non-refundable check for \$460.00 payable to the Board of Examiners for Nursing Home Administrators, and mail to the above address. Please type or print legibly.
2. Attach one (1) "passport" style photograph to the front of this application.
3. Attach, or have sent, two (2) original letters of reference written on signator's letterhead stationery (no copies). These letters must verify your good moral character, be signed and dated within the last twelve (12) months.
4. Attach one (1) certified or notarized photocopy of a birth certificate, naturalization papers or current visa.
5. Request your transcript from the College or University you obtained the degree, and have it sent directly to the Board Office at the above address. Your transcript should state the title of the degree and the date you graduated.
6. Resume of last five (5) years
7. A criminal background check must be submitted. For instructions on how to obtain a criminal background, [click here](#).
8. A profile questionnaire must be submitted with this application. To obtain a profile questionnaire, [click here](#).
9. Reciprocity applicants must also request employer (s) verification letter (s) of the last three (3) years
10. All applicants must complete the declaration of citizenship attachment.

NAME _____
First Middle and/or Maiden Last

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

CURRENT HOME MAILING ADDRESS: _____
CURRENT PRACTICE NAME AND ADDRESS: _____

HOME PHONE #: _____ WORK PHONE #: _____

HOME E-MAIL ADDRESS: _____ WORK E-MAIL ADDRESS: _____

Do you wish to receive notification, including renewal notification from the Department of Health via email? YES NO

List all states where you currently have, or have ever had, a Nursing Home Administrator license. If you need additional space please attach information to the back of this page.

If you have an associate, baccalaureate, masters, or doctorate degree please list the following:

Name of College or University: _____ Type of Degree Awarded: _____

Major: _____ Date of Graduation: _____

EDUCATION AND/OR EXPERIENCE REQUIREMENT

Please indicate which educational and/or experience requirement you have completed for licensure in Tennessee or the requirement you completed to receive a nursing home administrator's license in another state.

- () 1. Baccalaureate, masters or doctorate degree in the area of health care administration from an accredited college or university with four hundred (400) hour Internship taken for credit and served in a licensed long term care nursing facility.
- () 2. Baccalaureate, masters or doctorate degree from an accredited college combined with a Board-approved Administrator-In-Training program of at least six (6) months.
- () 3. Associate degree and five (5) years of acceptable management experience as defined in rule 1020-1-.07 (1), combined with a Board approved Administrator-In-Training program of least six (6) months. To review the acceptable management experience rule, please visit: <http://www.state.tn.us/sos/rules/1020/1020-01.20130313.pdf>.
- () 4. Combination of education and acceptable management experience as a hospital administrator and/or assistant or associate/hospital administrator. Applicant must have spent a minimum of five (5) of the last seven (7) years in full time hospital administration as either the chief executive officer or chief operating officer of a licensed hospital, and also obtained a baccalaureate, masters or doctorate degree from an accredited college with a four hundred (400) Board-approved Administrator-In-Training program completed in no less than three (3) months and no more than six (6) months combined.
- () 5. Licensure by reciprocity.

If you checked # 1, complete pages 1, 2, 3, and 4 and have your college or university send a sealed transcript directly to the Board office. Enclose a resume for at least five (5) years, listing last employment first, including proof internship was completed in a long term care facility. Please indicate on your resume the name of the facility and the beginning and ending dates of where you completed your internship.

If you checked # 2, complete pages 1, 2, 3, 4, 6, have your preceptor complete page 7 and have him/her retain pages 8 and 9. Have your college or university send a sealed transcript directly to the Board office. Enclose a Resume for at least five (5) years, listing last employment first.

If you checked # 3, complete pages 1, 2, 3, 4, 6, have your preceptor complete page 7 and have him/her retain pages 8 and 9. Have your college or university send a sealed transcript directly to the Board office. Enclose a resume for at least the last five (5) years, listing last employment first.

If you checked # 4, complete pages 1, 2, 3, 4, 6, have your preceptor complete page 7 and have him/her retain pages 8 and 9. Have your college or university send a sealed transcript directly to the Board's office. Enclose a resume for at least the last five (5) years, listing last employment first.

If you checked # 5, complete pages 1, 2, 3, 4, . Also, check additional educational or experience requirements in 1 through 4 of how you are educationally qualifying. If you are applying by reciprocity, you will check two (2) options.

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application. For the purpose of these questions, the following phrases or words have the following meanings:

1. **“Ability to practice as a Nursing Home Administrator”** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate decisions (if necessary) and exercise reasoned judgment and to learn and keep abreast of development in the field.
 - b. The ability to communicate those judgments and information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers.
 - c. The physical capability to perform tasks and procedures required or your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **“Medical Condition”** includes physiological, mental or psychological disorders, such as, but not limited to: orthopedic, visual, speech and/or hearing impairment, cerebral palsy, epilepsy, muscular dystrophy, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
3. **“Chemical Substances”** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.
4. **“Currently”** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that use of drugs or alcohol may have an ongoing impact on one’s functioning as a licensee, or within the past two (2) years.
5. **“Illegal Use of Controlled Substances”** means the use of controlled substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	YES	NO
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice as a Nursing Home Administrator with reasonable skill and safety? a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner, in which you have chosen to practice? (If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether conditions should be imposed or whether you are not eligible for licensure.)	_____ _____ _____ _____	_____ _____ _____ _____
2. Do you currently use chemical substances? If yes, do they in any way limit your ability to practice as a Nursing Home Administrator with reasonable skill and safety?	_____ _____	_____ _____
3. Are you currently engaged in the illegal use of controlled substances? If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaged in illegal use of controlled substances?	_____ _____	_____ _____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5. If you have ever held or applied for a license or certificate to practice as a Nursing Home Administrator or any other health care professional in any state, county, or province, was or has it ever been denied, reprimanded, suspended, restricted, revoked or otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

6. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8. Have you ever been rejected or censured by a Professional Association?	_____	_____
9. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you?	_____	_____
b. Have you ever had settlement of any legal action rendered <u>against</u> you?	_____	_____
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
10. U. S. Citizen: All applicants must complete the Declaration of Citizenship attachment		

AFFIDAVIT OF APPLICANT

AUTHORIZE I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying statements and transcripts are true, complete and correct. I understand that any false or misleading information in or in connection with my application may be cause for denial or loss of my license.

I further swear that I have read and understand the statues and the Rules and Regulations which were enclosed in the application packet and agree to abide by them while licensed by Tennessee.

I also authorize the Board of Examiners for Nursing Home Administrators to be informed if my name appears on the Tennessee Abuse Registry and do hereby waive the confidentiality of said information only for the limited purpose of processing my licensure application.

In order to comply with federal statutes, the Tennessee Board of Examiners for Nursing Home Administrators is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

Signature of Applicant

Sworn to and subscribed before me this _____ day of _____, _____.

Commission Expires: _____
(Date)

(Notary Public)

(Notary Seal)



STATE OF TENNESSEE
 DEPARTMENT OF HEALTH
 OFFICE OF HEALTH RELATED BOARDS
 665 MAINSTREAM DRIVE
 NASHVILLE, TN 37243
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 TOLL FREE 1-800-778-4123 ext. 7413807

TENNESSEE BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS

Please complete the top portion and mail this form to the regulatory board in each state where you hold or have held a license to practice as a Nursing Home Administrator. (If additional forms are required, this form may be duplicated.) Please disregard this page if you are not licensed or have never been licensed as a nursing home administrator in another state.

NOTE: Some states require a fee for providing verification information. In order to expedite your application, please contact the applicable state(s) inquire about required fees.

I was granted _____ on _____ by the State of _____
 (License #) (Date)

The Tennessee Board of Examiners For Nursing Home Administrators requests that I submit evidence that my License in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Examiners For Nursing Home Administrators.

Date: _____ Signature: _____

SSN#: _____ Printed Name: _____

THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD

License Number: _____ Date Issued: _____

Basis of Issuance: Endorsement/Reciprocity With: _____
 (Provide Description of Exam)

Written Examination: NAB _____ PES _____ OTHER _____ DATE _____

Raw Score _____ Scale Score _____

Was an A.I.T./Practicum successfully completed: _____ Length of A.I.T./Practicum _____

License currently registered: _____ Yes _____ No

Derogatory Information on File: _____ Yes _____ No

If "yes" please attach explanation.

 Authorized Signature

 Title

 Date

State Seal



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APPLICATION FOR ADMINISTRATOR-IN-TRAINING

Name: _____

Facility Name & Address: _____

Street	City	State	Zip
County	Telephone	()	

I have entered into an agreement with _____ License #: _____
to serve as my preceptor during the period approved by the Board.

I hereby agree to hold the Tennessee Board of Examiners for Nursing Home Administrators, its members, officers, staff and examiners free from any damage or complaint by reason of any action they, or any of them, may take in connection with this application.

I understand that my A.I.T. program may not begin until notification of approval of my application by the Board.

I further understand that approval of my A.I.T. application does not imply approval to take the Nursing Home Administrators License Examination. Approval of qualifications to take the examination will be made after I complete my A.I.T. program.

I am also aware that I shall be assigned responsibilities in departmental rotation eight consecutive hours daily (except for regular days off), with a minimum of forty hours per week unless alternate arrangements are made with the Board in writing.

I further agree that I shall have no other "full or part time" work assignments in the facility during training hours, or any outside employment, unless such employment is known to and approved in writing by the Board and the preceptor prior to the start of my A.I.T. program.

By voluntarily entering into the A.I.T. program in an effort to become licensed as a Nursing Home Administrator, you are giving your permission to your Preceptor to evaluate your performance as regarding your qualifications as an administrator. You should consult your attorney concerning any legal relationship or right as between you and your Preceptor.

I will submit the most recent survey of the facility in which I will complete my A.I.T. program.

APPLICANT'S SIGNATURE IN FULL _____

Subscribed and sworn before me this _____ day of _____, _____.

My Commission Expires: _____

(SEAL)

Notary Public



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PRECEPTOR AND ADMINISTRATOR-IN-TRAINING APPLICATION FOR TRAINING FACILITY

The primary training of an Administrator-In-Training will take place in the Nursing Home of which the Preceptor is Administrator.

Name of Nursing Home: _____

Address: _____ Telephone: (____) _____

Street Number and Name

City

State

Zip

Attach a copy of the latest licensure survey and the plan of correction for any deficiencies.

The facility must have an organizational structure with clearly defined and staffed departments, each with a designated department head. Except for administration, the designated department head may not be the administrator.

DEPARTMENT

NAME OF DEPARTMENT HEAD

Administration: _____

Nursing: _____

Dietary: _____

Social Services and Activities: _____

Medical Records: _____

Housekeeping, Maintenance, Laundry: _____

Number of Beds: _____

AUTHORIZE I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

I, _____, the Administrator of Home, hereby make application to the Tennessee State Board of Examiners for Nursing Home Administrators for approval of this Nursing Home as an Administrator-In-Training facility and for approval to function as a preceptor. All facts, statements and answers contained in this application are true and correct, to the best of my knowledge. I have not omitted any information which might be of value to the Board in determining the qualifications of this Nursing Home, whether it is called for or not, and I understand that any falsification, omission or withholding of information or facts concerning the home's qualifications shall be sufficient to bar it from this or any future certification given by the Tennessee State Board of Examiners for Nursing Home Administrators as an A.I.T. site.

Signature of Administrator

Date

County of _____, State of _____.

Sworn to and subscribed before me by the above this _____, day of _____, _____.

Notary Public

(SEAL)

My Commission Expires: _____



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ADMINISTRATOR-IN-TRAINING

PROGRESS REPORT NUMBER: _____

Name of A.I.T.: _____

Name of Preceptor: _____

Training Site: _____

Date A.I.T. program began: _____

Dates covered by this report: _____

1. List assignments and departments with time spent in each: _____

2. Summary of learning experiences: _____

3. Brief analysis of any problems observed, new experiences, insights gained: _____

4. Statement of any problems that arose during the period: _____

5. Visits outside the facility, educational conferences attended: _____

I certify, to the best of my knowledge, that the information presented is true and accurate and I have had at least four (4) hours of face-to-face training with this A.I.T. each week of this reporting period.

Signature of Preceptor

Date

Progress reports must be submitted every 2 or 3 months. **Make extra copies of this page.** Additional comments may be made on a separate sheet of paper. **(Do not change any party of this form.)**



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Evaluation Report of the Six (6) Month A.I.T. Program
 Must be in BENHA Office for Approval by the FULL Board
 This Evaluation Report must be submitted with the third (3rd) and Final Report

I, _____, Preceptor for _____,

certify that he/she has successfully completed the Administrator-in-Training program at:

_____ Nursing Home.

I certify that I have had at least four (4) hours face-to-face training with this A.I.T. each week of the training.

The Administrator-in-Training program began on _____ and was completed on _____.

During this period, there was a total of _____ hours spent in the training program. The hours were divided as follows:

<u>Department</u>	<u>Hours</u>
Administration	_____
Activities	_____
Bookkeeping	_____
Business Office	_____
Dietary	_____
Housekeeping	_____
Laundry	_____
Maintenance	_____
Medical Records	_____
Nursing	_____
Social Services	_____
Other: _____	_____
_____	_____
_____	_____
Total Hours:	_____

On a separate sheet of paper, please evaluate this prospective administrator. The Board needs your evaluation of the A.I.T.'s strengths and weaknesses in each of the above areas in order to properly guide him/her toward licensure. All reports, evaluation report, evaluation of A.I.T.'s strengths and weaknesses and recommendation letter to sit the NAB examination must be in the BENHA Office before the applicant can be approved to sit for the examination.



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
DECLARATION OF CITIZENSHIP

MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: _____
Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____) ____-____ Office: (____) ____-____ Fax: (____) ____-____
4. I am a United States Citizen: ___Yes ___No
5. I am a foreign national not physically present in the United States ___Yes ___No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - a) Permanent Residents
 - b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).

- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this ____ day of _____, 20__.

Signature

Sworn to before me this ____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.