



COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH PROFESSIONS LICENSURE
BOARD OF REGISTRATION OF NURSING HOME ADMINISTRATORS
239 CAUSEWAY STREET, SUITE 500
BOSTON, MA 02114
800-414-0168
617-973-0806
www.mass.gov/dph/boards/nh

INSTRUCTIONS FOR NURSING HOME ADMINISTRATOR LICENSE APPLICATION

GENERAL INFORMATION: Applicants for a Nursing Home Administrator licensure **MUST** have completed an Administrator in Training internship approved by the Massachusetts Board to be eligible to submit a licensure application and take the national credentialing examination.

General Information About the Application Process:

Once an application is received by the Board, it takes a **minimum of 3- 5 weeks** to review the completed application and determine if any additional information is required. Once complete, applications are processed for the issuance of a license in the order received. Every effort is made to process license applications in a timely manner; however, the Board is unable to expedite the processing of applications.

To facilitate the processing of your application, please ensure that you provide all the information requested. **DO NOT LEAVE BLANKS.** If you are unable to provide the requested information, attach a separate sheet with an explanation. Missing information will delay the processing of your application.

As an applicant, it is your responsibility to ensure that ALL supporting documentation for licensure is sent directly to the Board and to check with the Board on the status of your application.

All requested information must be provided; failure to provide requested information may result in a delay in processing of application. Incomplete applications will be returned to applicant.

Completed Applications must include the following:

1. **The following documents must be submitted at the same time in one envelope:**
 - a. Completed application form, signed and dated by the applicant and notarized.
 - b. 2 x 2 passport style color photo (white or off-white background); copies and printer generated photos are not acceptable.
 - c. Signed and notarized Criminal Offender Record Information (CORI) Acknowledgement Form obtained from the Board's website.
 - d. Check or money order payable to the Commonwealth of Massachusetts for \$150.00; cash or foreign currency is not accepted.
 - e. Three professional references. **Note:** may not be relatives, spouses, family members, subordinates or your AIT preceptor.

- f. One personal reference. **Note:** may not be a spouse, partner, family member, subordinate or your AIT preceptor.
- g. Completed physician form.
- h. Completed Administrator Affidavit.

NOTE: Provide a self-addressed envelope to your endorsers with your Reference Forms, Physician Form, and Administrator Affidavit Certificate of Internship Training. After the individual has completed the form, he/she must seal it in the return envelope you provide, sign his/her name across the envelope seal, and return it to you.

- 2. Official transcripts in signed, sealed envelopes for all undergraduate degrees and any other post-secondary degrees. When requesting official transcripts, please inform each school's registrar that the **transcript must be complete and indicate the degree and date conferred in mm/dd/yyyy format.**
- 3. Verification of licensure status, in signed, sealed envelopes, from any state or jurisdiction in which you now or have previously held any professional license. Verifications must be sent directly to the Board by the state or jurisdiction.

NOTE: If verifications have been previously submitted with an application for administrator in training program, they do not need to be submitted again **if they were issued within the past 12 months.**

- 4. If you hold, or have ever held, any professional license or certification, you must request a National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self-Query and submit the **Original** report in a signed and sealed envelope with this application. To request a Self Query, please contact the National Practitioner Data Bank at 1-800-767-6732 or <http://www.npdb.hrsa.gov>. Keep a copy for your records.

NOTE A: If you do NOT hold and have never held any professional licenses in any other state, you do not need to submit a National Practitioner Data Bank self-query.

NOTE B: If a National Practitioner Data Bank self-query was submitted with an application for administrator in training program, it does not need to be submitted with an application for full licensure **if it was certified and sent within the past twelve months.**

- 5. Once the application packet is submitted and all required documents are received by the Board, it will be reviewed. The Board will notify you by letter with information regarding contacting Professional Examination Services to register for the credentialing examination and scheduling a test date.

NOTE: More information about the examination is available on the National Association of Boards of Examination of Long Term Care Administrators' [NAB] website at www.nabweb.org. A handbook, *Information for Candidates, Nursing Home Administrators*, is available for purchase.

6. Applications are void if requirements for nursing home administrator licensure by examination are not met within one (1) year from the date of Board receipt of this application. **All fees are non-refundable and non-transferable.**
7. Applications must be submitted on single-sided paper.
8. Retain a copy of the complete application and supporting documentation for your records. **The Board is not able to provide copies of the application.** Employers may require that you provide them with a copy.

IMPORTANT INFORMATION

A nursing home administrator applicant/licensee must notify the Board in writing of any changes in the applicant's/licensee's information within thirty (30) days of their occurrence, including but not limited to any change of address and any name change.

The address of record is where the Board mails your license and any correspondence. **Failure to update your address of record may result in failure to receive a license renewal application.**

The address printed on your license is a **PUBLIC RECORD** that is available to anyone who requests it. Address changes may be done online at the Board's website www.mass.gov/dph/boards/nh or you may obtain a form online to submit to the Board's office.

Answers to many questions may be found on the Board's website (www.mass.gov/dph/boards/nh). Statutes and regulations governing nursing home administrator licensure may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168 or 617-973-0806.



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NURSING HOME ADMINISTRATOR LICENSE APPLICATION PACKET CHECKLIST

The following must be included for a complete application. Please complete and enclose this checklist with your application. Applications will not be reviewed until all required and requested documentation has been received.

- Completed Application Form with
 - Signed and notarized affidavit
 - 2x2 passport style color photo
 - Signed and notarized Criminal Offender Record Information (CORI) Acknowledgement Form

- Application Fee of \$150.00(check or money order only)

- Resume

- Four Completed Reference Forms (signed and sealed envelopes):
 - 3 professional
 - 1 personal

- Physician Form (signed and sealed envelope)

- Administrator Affidavit Certificate of Internship Training(signed and sealed envelope)

- National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank **Original** report (if you hold, or have ever held, a professional license and have not submitted a report within the past twelve months).

- Application must be submitted on single-sided paper.

EDUCATION

9. BACHELOR'S DEGREE SCHOOL NAME/LOCATION: _____

DEGREE: _____ DATE AWARDED: ____/____/____
(MM/DD/YYYY)

Submit official transcript in a signed, sealed envelope. Transcripts must be mailed directly to the Board. If transcripts were previously submitted with an application for the AIT Program they do not need to be sent again, if they were submitted within the past 12 months.

10. OTHER POST-SECONDARY INSTITUTION(S)/LOCATION(S): _____

DEGREE: _____ DATE AWARDED: ____/____/____
(mm/dd/yyyy)

Submit official transcript in a signed, sealed envelope. Transcripts must be mailed directly to the Board. If transcripts were previously submitted with an application for the AIT Program they do not need to be sent again, if they were submitted within the past 12 months.

Please list additional post-secondary institutions on a separate sheet and request that transcripts be submitted directly to the Board as noted above.

VERIFICATION OF OTHER LICENSES/BOARD CERTIFICATIONS

11. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS EVER HELD; INCLUDE ALL STATES AND JURISDICTIONS

I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.

<u>Issuing State/Jurisdiction</u>	<u>Profession</u>	<u>License/Certification Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicants must arrange for official documentation of current license status from each state or jurisdiction to be mailed directly to the Board.

REFERENCES

12. List the names of the three professional people whom you have asked to file a reference form with this application. (Note: references may not be a spouse, partner, family members, subordinates or AIT preceptor.)

A. Name _____

Title or position _____

B. Name _____

Title or position _____

C. Name _____

Title or position _____

PERSONAL CHARACTER REFERENCE

Provide the name of a personal reference who you have asked to file a reference with this application. (Note: reference may not be a spouse, partner, family member, subordinate or AIT preceptor.)

D. Name _____ Years Known _____

QUESTIONS

If you answer "YES" to any of the following questions please attach a separate sheet explaining the circumstances.

13. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?

Yes No

14. Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes No

15. Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes No

16. Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes No

17. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$250 or less was imposed.

Yes No

18. Have you ever been court martialled or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes No

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Nursing Home Administrators any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Nursing Home Administrators to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a nursing home administrator I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a nursing home administrator in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure shall be deemed no longer valid if requirements for licensure are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration of Nursing Home Administrators to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

NOTARY NAME: _____

COMMISSION EXPIRES: _____

Attach a recent color 2x2 passport photo

[Seal]

INCLUDE A NONREFUNDABLE , NONTRANSFERABLE FEE OF \$150.00 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS

ATTENTION:

MAKE 4 COPIES OF THE FOLLOWING 2 PAGES



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REFERENCE FORM

You have been requested to provide reference information for _____,
an applicant for registration as a Nursing Home Administrator in Massachusetts under the
provisions of Section 74, Chapter 13 of the General Laws of this Commonwealth. Pertinent
information concerning the applicant will be helpful to the Massachusetts Board of Registration of
Nursing Home Administrators.

In order that the provisions of the licensing law may be effective in safeguarding public health,
safety and welfare, the Board of Registration of Nursing Home Administrators has been charged
with the responsibility of limiting the use of the title "Nursing Home Administrator" only to those
who are found qualified and suitable for that profession. As one of the applicant's references, you
are familiar with his/her professional work or have knowledge of his/her ability, character and
reputation. The Board would appreciate information that bears upon the extent of the
responsibility borne by the applicant in his/her professional work as well as your opinion of his/her
professional competence and character.

The Board appreciates your cooperation in supplying the information requested on the enclosed
sheet. Once you have completed the form, please place it in the envelope, sign your name
across the envelope seal, and return it to the applicant.

MASSACHUSETTS BOARD OF REGISTRATION OF NURSING HOME ADMINISTRATORS

REFERENCE FORM

PLEASE TYPE OR PRINT CLEARLY:

1. NAME OF APPLICANT _____

2. PROFESSIONAL OR OTHER RELATIONSHIP TO APPLICANT

3. NUMBER OF YEARS YOU HAVE KNOWN THE APPLICANT _____

4. PLEASE EVALUATE THE APPLICANT IN THE CATEGORIES OF WHICH YOU HAVE PERSONAL KNOWLEDGE:

a. PROFESSIONAL KNOWLEDGE AND EXPERIENCE:

b. CHARACTER WITH RESPECT TO HONESTY, INTEGRITY, AND GENERAL CONDUCT:

5. DO YOU RECOMMEND THE APPLICANT FOR LICENSURE AS A NURSING HOME ADMINISTRATOR?

Yes _____ No _____ If No, please attach a detailed written explanation of your reasons for not recommending this applicant.

6. OTHER COMMENTS:

(Attach an additional sheet of paper, if you wish to make additional comments)

I hereby certify that the information given above is correct to the best of my knowledge and belief, and opinions expressed above represent my best judgment. I hereby agree to provide further information to the Board if requested to do so.

Name (type or print clearly)

Signature

Business Address

Date

City/State

Zip Code

Occupation

Home Address

City/State

Zip Code



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PHYSICIAN FORM

1. NAME OF APPLICANT: _____

2. NAME OF LICENSED PHYSICIAN: _____

3. ADDRESS OF PHYSICIAN: _____

No. Street Apt. #

City/Town State Zip Code

4. PHYSICIAN STATE LICENSE NUMBER: _____

License Number

Expiration Date

I hereby certify that the above named applicant is in good health and has no mental or physical impairment that would prevent him or her from discharging the responsibilities of a Nursing Home Administrator.

Physician Signature

Date

Once you have completed this form, please place it in an envelope, sign your name across the envelope seal, and return it to the applicant.



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**ADMINISTRATOR AFFIDAVIT
CERTIFICATE OF INTERNSHIP TRAINING**

(Trainee Name) (Degree Level)

I, _____, _____, hereby certify that
(Administrator) (License number)

the trainee named above has trained in the _____
(Name of Nursing Home)

from _____ to _____, working
(mm/dd/yyyy) (mm/dd/yyyy)

_____ hours per week, for a total of _____ hours.

During this training period, the trainee named above has worked as an Administrator In Training; if the trainee held another position at the facility during the AIT, the AIT training has been completed separately from the normal working hours for that position. During the course of this training, the trainee was exposed to all aspects of nursing home management and the operation of the named facility, including the following: admittance procedures, patient care policies, utilization review processes, in-service training procedures, social services, medical records, housekeeping and sanitation, dietary and kitchen operations, medical department and applicable rehabilitation procedures, laundry services, purchasing procedures, personnel department procedures and policies, management functions including budgeting, billing, accounts receivable and payable, and departmental scheduling, etc.

I have been licensed in good standing for at least five years.

UNDER THE PENALTY OF PERJURY, THIS AFFIDAVIT HAS BEEN SIGNED AFTER THE COMPLETION DATE OF THE AIT.

Signature of Administrator

Date

Notary Public

Notary Expiration Date

Effective Date of This Document

Seal