DEPARTMENT OF HEALTH
BOARD OF NURSING HOME ADMINISTRATORS
4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257
850/245-4355

APPLICATION INSTRUCTIONS FOR ADMINISTRATOR-IN-TRAINING

*** PLEASE TYPE OR PRINT IN BLACK INK ***
PLEASE READ CAREFULLY

(Section 468.1695(4), Florida Statutes and Chapter 64B10-16, Florida Administrative Code)

THE FOLLOWING ITEMS MUST BE INCLUDED WITH YOUR APPLICATION:

You must COMPLETE your AIT program BEFORE you submit your application for exam and last report approved.

APPLICANT'S QUESTIONS REGARDING APPLICATION STATUS: Within thirty (30) days after the board office receives your application and fee, we will send an acknowledgment letter informing you of any deficiencies and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date mailed, please contact this office. As a reminder to all applicants, Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

Florida Laws and Rules: A copy of Section 468, Part II, Florida Statutes and Rule Chapter 64B10, Florida Administrative Code are enclosed or you may download them at http://www.doh.state.fl.us/mqa/nurshome/nha_statute.html This information is also available over the internet via our web site. It is important to read this in order to determine your eligibility prior to applying, and to familiarize yourself with the statutes and board rules regarding your application for licensure as a nursing home administrator within the State of Florida.

Fee Schedule: A certified check or money order in the appropriate amount, made payable to the Department of Health, must be attached to your application. Please staple the certified check or money order to page 1 of the application on the upper left part of the form. Your application will not be processed without these fees. These fees are required by law and include the following:

1,000 Hour AIT Program:

Application Fee	$ 250.00
Unlicensed Activity Fee	$ 5.00
Total Fee	$ 255.00

2,000 Hour AIT Program:

Application Fee	$ 350.00
Unlicensed Activity Fee	$ 5.00
Total Fee	$ 355.00

One Photographs: Write your name on the back of the "passport type" (i.e., full-face) photographs and staple them to the bottom right side of the first page of the application. The photograph should be approximately 2" by 2" and be a clearly recognizable picture of your full-face, taken within the last six months.

Final Official Undergraduate Transcript: A final official transcript must be sent directly from the educational institution/college to this office. Transcripts submitted by the applicant or indicating "issued to student" are not acceptable; a copy of your diploma will not be accepted in lieu of an official transcript. Please note that it is your responsibility to follow-up with your educational institutions to ensure that they have received and complied with your requests. The board office will notify you as items are received.

AIT REVIEW AND STUDY TRAINING MANUALS: Please be advised the Board of Nursing Home Administrators is not requiring these manuals, but simply suggesting them for your use. To receive additional information on these manuals go to the board's web site at www.doh.state.fl.us/mqa/nurshome/nha_applications.html

NURSING HOME ADMINISTRATORS

--- ADMINISTRATOR-IN-TRAINING (AIT) ---

APPLICATION CHECKLIST

_____ 1. Application:
- All questions answered on all pages and if question not applicable, mark with N/A.
- All "Yes" answers must be accompanied by an explanation or affidavit, as instructed.
- Public Records Disclosure Form SSN

_____ 2. Fees:
- Please make certified check or money order payable to **DOH–Board of Nursing Home Administrators.**

_____ 3. Photo:
- Attached (1) 2"x2" photo to application. HEAD AND SHOULDERS ONLY.

_____ 4. Qualified Preceptor Agreement

_____ 5. Training:
    _____ a. AIT 1,000 hours
    _____ b. AIT 2,000 hours

_____ 6. Official College Transcript

_____ 7. AHCA Survey

_____ 8. Facility Organizational Chart (Submit with application)

RETURN APPLICATION, FEES, AND SUPPORTING DOCUMENTS TO:

Florida Department of Health
Board of Nursing Home Administrators
Post Office Box 6330
Tallahassee, Florida 32314-6330

ADDITIONAL DOCUMENTATION, NOT ACCOMPANIED BY A FEE, SHOULD BE SENT TO:

Florida Department of Health
Board of Nursing Home Administrators
4052 Bald Cypress Way, BIN # C07
Tallahassee, Florida 32399-3257

FLORIDA DEPARTMENT OF HEALTH

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Board of Nursing Home Administrators

Name:

____

Last **First** **Middle**

Social Security Number:

____

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

4052 Bald Cypress Way, Bin # C07
Tallahassee, Florida 32399-3257

ADMINISTRATOR-IN-TRAINING APPLICATION
(Client 801)

Mail To: Board of Nursing Home Administrators
Post Office Box 6330
Tallahassee, Fl 32314-6330
http://www.doh.state.fl.us/mqa/nurshome/nha_home.html
(850) 245-4355

APPLICATION CATEGORY: (Must select one category – ONLY)

[ ] 1,000 Hour AIT Program - $255.00 (1009)   [ ] 2,000 Hour AIT Program - $355.00 (1009)

PROFILE DATA (Please print or type or application will be returned):

1. **NAME:** ____
(Last) (First) (Middle)

2. **MAILING ADDRESS:** ____
(Street and Number) (Apt. #) (City) (State) (Zip)

PRIMARY LOCATION: ____
(Street and Number) (Apt. #) (City) (State) (Zip)

3. **TELEPHONE:** (___)______________________(___)________________________
Home: Area Code/Phone Number   Work: Area Code/Phone Number

4. **LICENSE NUMBER(If licensed another state):** __________

5. **E-MAIL ADDRESS:** _________________

6. **US Citizen:** [ ] Yes [ ] No

7. **Date of Birth:** ________________ **Place of Birth:** _______________

8. **PERSONAL DATA -** We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.
RACE: [ ] Caucasian [ ] African-American/Black [ ] Hispanic [ ] Asian [ ] Native American [ ] Other
SEX: [ ] Male [ ] Female

9. **EDUCATIONAL DATA:**

Degree Title: ____

4 Year _____ Master _____ Doctorate _____

Name of College or University: ____

Address: ____
(Street and Number) (City) (State) (Zip)

Date of Graduation: ____________________ Accredited by: ______________________________

Staple Photo
DO NOT GLUE
PASTE OR TAPE

Rule 64B10-16.001, F.A.C.
DH-MQA-NHA003 – Revised 8/08

10. NURSING HOME AT WHICH A.I.T. PROGRAM WILL BE PROVIDED:

Name of Nursing Home: ____

Address: ____
(Street and Number) (City) (State) (Zip)

11. APPLICANT SIGNATURE:

I, the undersigned, state that I am the person referred to in this application for licensure in the State of Florida.

I state that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.082, 775.083, and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instruments (local, state, federal or foreign) to release to the Department of Health, any information, files and/or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organization, individuals, and groups listed above, any information which is material to my application.

I understand that Florida law requires me, as an applicant for licensure, to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board of Nursing Home Administrators decision concerning my eligibility for licensure. (Section 456.013, Florida Statutes) Failure to do so may result in action by the Board including denial of licensure.

I further state that I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I understand that such action shall constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida in the profession for which I am applying.

I also state that I will comply with all requirements for licensure renewal in effect at the time of license renewal, including submission of appropriate renewal fees and completion of required continuing education credits.

As a reminder to all applicants, please understand that Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the Department.

_______________________________________ _______________________
(Signature of Applicant) (Date)

Completed by Preceptor:

Name of Preceptor: ____

Mailing Address: ____
(Street and Number) (City) (State) (Zip)

E-mail Address: ______________________________

Telephone Number: ___________________________

License #: __________ Preceptor # C-: __________

AHCA Licensure Status Standard or Conditional:
(**Attached a copy of the latest AHCA Survey Report**) ______________________

Number of Beds: __________ SNF: __________ ICF: __________

Administrator-in-Training Agreement:

This agreement entered into by the Administrator-Preceptor, ________________________,

the Administrator-in-Training, _______________________ and agree to the following conditions:

The Administrator-Preceptor shall provide supervision and guidance as designated for a ___________________ period of time commencing on ___________________ as set out in the guidelines of the Administrator-in-Training Program as provided in the Administrator-Preceptor's Training Course.

The Administrator-in-Training shall perform under the supervision of a duly qualified Administrator-Preceptor and fulfill all terms and conditions required.

_______________________________________ _______________________
(Signature of Administrator-Preceptor) (Date)

_______________________________________ _______________________
(Signature of Administrator-in-Training) (Date)

FACILITY ORGANIZATIONAL CHART
(Preceptor Should Complete)

Name of Employee	Date Employed	License Number	Number of Hours Worked Daily						
			Sun	Mon	Tue	Wed	Thur	Fri	Sat
Activity Coordinator									
Administrator-in-Training									
Business/Finance Director									
Dental Consultant									
Dietary Consultant									
Director of Nursing									
Food Service Supervisor									
Housekeeping Supervisor									
Maintenance Supervisor									
Medical Director									

FACILITY ORGANIZATIONAL CHART
(Preceptor Should Complete)

Name of Employee	Date Employed	License Number	Number of Hours Worked Daily						
			Sun	Mon	Tue	Wed	Thur	Fri	Sat
Medical Records Consultant									
Nursing Home Administrator									
Occupational Therapist									
Pharmacy Consultant									
Physical Therapist									
Preceptor									
Social Service Director									
Volunteer Coordinator									

Statement of Administrator-in-Training/Preceptor:
We hereby declare that to the best of our knowledge and belief, there are no misrepresentations or falsifications in the statements and answers we have given in this application or in any other documents or papers appended hereto.

____ _____________________________________
(Signature of Administrator) (Date)

____ _____________________________________
(Signature of Administrator-in-Training) (Date)