

Administrator-in-Training Application



**Board of Nursing Home Administrators
P.O. Box 6330**

Tallahassee, FL 32314-6330

Website: www.floridasnursinghomeadmin.gov

Email: info@floridasnursinghomeadmin.gov

Phone: (850) 245-4355

FAX: (850) 922-8876





Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at

<http://www.flhealthsource.gov/valor>





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Do Not Write in this Space
For Revenue Receiving Only

1,000-hour (6 month) Administrator-in-Training (A.I.T.) Program (1009) \$255.00

2,000-hour (1 year) A.I.T. Program (1009) \$355.00

Total fee includes the following:

	<u>1,000-hour</u>	<u>2,000-hour</u>
Application Fee	\$250.00	\$350.00
Unlicensed Activity Fee	\$5.00	\$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. The application fee is non-refundable.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

Street/P.O. Box Apt. No. City

State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

Street Apt. No. City

State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 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.

Gender: Male	Race: Native Hawaiian or Pacific Islander	Hispanic or Latino	White
Female	American Indian or Alaska Native	Black or African American	Asian
	Two or More Races		

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

If you responded “No” to the question above, skip to question 5.

- a. Have you been in good standing with a state Medicaid program for the most recent five years?
Yes No
- b. Did termination occur at least 20 years before the date of this application? Yes No
5. Are you currently listed on the United States Department of Health and Human Services’ Office of the Inspector General’s List of Excluded Individuals and Entities (LEIE)? Yes No
- a. If you responded “Yes” to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No
- b. If you responded “Yes” to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded “Yes” to any of the questions in this section, provide the following:

A written self-explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

Supporting documentation including court dispositions or agency orders where applicable.

Documents for this section must be mailed to:

Board of Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

6. APPLICANT SIGNATURE

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

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, 456.072, 468.1745 and 468.1755, F.S.

I understand that Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed. Failure to do so may result in action by the board including denial of licensure.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
MM/DD/YYYY

Name: _____

*Board of Nursing Home Administrators
Preceptor Agreement*



This form must be completed by your Preceptor

Name of Preceptor: _____

Facility Address: _____
Street and Number City State ZIP

Email Address: _____

Telephone Number: _____

License Number: _____

AHCA Licensure Status: Standard Conditional

(Attach a copy of the latest AHCA Life Safety Survey Report and revisit report with letter stating all deficiencies are complete)

Number of Beds: _____ SNF: _____ ICF: _____

Administrator-in-Training Agreement

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

the Administrator-in-Training, _____ agree to the following conditions:

The Administrator-Preceptor shall provide supervision and guidance as designated for a:

1,000-hour (6-month) program 2,000-hour (1-year) program

commencing on _____ as set out in the guidelines of the Administrator-in-Training Program
(MM/DD/YYYY)

as provided by 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.

Administrator-Preceptor Signature: _____ Date: _____
MM/DD/YYYY

Administrator-in-Training Signature: _____ Date: _____
MM/DD/YYYY

Name: _____



Board of Nursing Home Administrators Facility Organization Chart

This form must be completed by Preceptor

Name of Employee	Reports To
Activity Coordinator	
Assisted Administrator	
Business/Finance Director	
Director of Nursing	
Food Services Supervisor	
Housekeeping Supervisor	
Maintenance Supervisor	
Medical Director	
Nursing Home Administrator	
Pharmacy Consultant	
Rehab Director	
Risk Manager	
Social Services 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 paper appended hereto.

Administrator-Preceptor Signature: _____ Date: _____
MM/DD/YYYY

Administrator-in-Training Signature: _____ Date: _____
MM/DD/YYYY