FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
ID#:
Receipt #:

Instructions and Application For

License As A

Nursing Home Administrator

☐ By Examination ☐ By Endorsement

☐ By American College of Health Care Administrators (ACHCA) Certification

Applicant - Print Name

LAST NAME	***FIRST NAME***	***MI***

Phone: (401) 222-5888 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-3352**

Revised 02/20/2013 jcp

GENERAL INFORMATION

Enclosures

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Statute

Chapter 5-45 entitled "Nursing Home Administrators" can be downloaded at the following website:

http://webserver.rilin.state.ri.us/statutes/title5/5-45/index.htm

Rules and Regulations

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

http://www.health.ri.gov/atoz/

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professions Regulation, 3 Capitol Hill, Room 105, Providence, RI 02908.

Application Process

You must submit the application and additional information. All items listed on the following applicable checklist must be submitted for an application to be considered complete. **APPLICATIONS ARE ONLY VALID FOR A ONE (1) YEAR PERIOD.**

You are responsible for notifying HEALTH, in writing, when your address changes.

Once completed, the application will be reviewed and you will be contacted in writing. NOTE: You may ***not*** practice as a Nursing Home Administrator in Rhode Island until you have an active license.

To obtain your licensure status and license number, please refer to the HEALTH Licensee Lookup website:

https://healthri.mylicense.com/Verification/

If you have any questions about the application process, please contact this office at (401) 222-5888.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 4 weeks from the date of issuance, and are mailed to the address furnished in the application.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

Read the following instructions carefully before you complete the application. **Only completed applications will be accepted.** Failure to submit all required information and appropriate documentation will result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. Illegible information will not be accepted.
3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.
4. Make a copy of your completed application before you submit it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application. You must respond to all sections of the application as instructed. If you attach separate pages as a continuation of the application, please clearly indicate the section for which such information is being reported.
2. Make a check or money order payable to the **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first page of the application. The application fee is NON-REFUNDABLE.
3. Do not submit the application without all applicable information, documentation and fee. Mail the application to:

Rhode Island Department of Health
3 Capitol Hill, Room 105
Providence, RI 02908-5097

APPLICATION CHECKLISTS

Please review the following checklists, **choose which one applies to you**, and include all of the required information to complete your Nursing Home Administrator application.

All applicants must include the following:

By Examination:

1. 18 years of age and 2 letters of good moral character;
2. Original BCI check from the RI Attorney General's Office; if positive BCI, a detailed explanation is required.
3. Bachelor's degree in health care administration
   OR
   Bachelor's degree and completion of 15 credit hours, with a copy of the course description from the accredited college/university catalog, with course title, course number, credit and grade for the required courses.
4. Completion of field experience, 350 hours within a 12 month period, in a Administrator-in-Training (AIT) capacity in a licensed nursing facility;
   a. Completed AIT Certification form and
   b. Confirmation of RI nursing facility's nursing home administrator active license.
5. An original or notarized copy of birth certificate for US born applicants
   OR
   Notarized proof of citizenship and eligibility for employment for foreign-born applicants;
6. Official school transcript(s), with registrar's signature and school seal;
7. Curriculum Vitae;
8. A passport-type 2 x 3 inch photograph, taken within 1 year; and
9. Notarized application.

Upon completed application, then

10. Completion of written NHA examination, with minimal passing score of 113.

By Endorsement:

1. 18 years of age and 2 letters of good moral character;
2. Original BCI check from the RI Attorney General's Office; if positive BCI, a detailed explanation is required.
3. Bachelor's degree *and* 3 years experience as a licensed nursing home administrator, within the most recent 5 years;
   OR
   Bachelor's degree *and* in a management position with no less than 3 years experience, within the most recent 5 years, having direct responsibility for overseeing and directing 3 or more licensed nursing home administrators:
   - Provide applicable facility names, addresses, license information along with an attestation from your superior confirming your management position and oversight.

   OR
   Bachelor's degree *and* completion of 15 credit hours, with a copy of the course description from the accredited college/university catalog, with course title, course number, credit and grade for the required courses.
4. Official school transcript(s), with registrar's signature and school seal;
5. Curriculum Vitae;
6. An original or notarized copy of birth certificate for US born applicants
   OR
   Notarized proof of citizenship and eligibility for employment for foreign-born applicants;
7. A passport-type 2 x 3 inch photograph, taken within one (1) year;
8. Notarized application; and
9. Evidence of a current license in good standing as a NHA in all alternate jurisdictions;
   a. Completed Interstate Verification form(s)

By ACHCA Certification:

1. 18 years of age and 2 letters of good moral character;
2. Original BCI check from the RI Attorney General's Office; if positive BCI, a detailed explanation is required.
3. Certified by American College of Health Care Administrators (ACHCA)
   - Notarized copy of certificate
4. Official school transcript(s), with registrar's signature and school seal;
5. Curriculum Vitae;
6. An original or notarized copy of birth certificate for US born applicants
   OR
   Notarized proof of citizenship and eligibility for employment for foreign-born applicants;
7. A passport-type 2 x 3 inch photograph, taken within 1 year;
8. Notarized application;
9. Evidence of a current license in good standing as a NHA in all alternate jurisdictions;
   - Completed Interstate Verification form(s)

State of Rhode Island

Application for License as a Nursing Home Administrator

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Certificate.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname. (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year 19

5. Home Address

It is your responsibility to notify HEALTH of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify HEALTH of all address changes.

This address will appear on the Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Type of School (University, College, Technical School, etc.)

Name of School

Date Graduated: Month Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, enter all other state licenses in Question 10 (below):

10. Licensure

List all states or countries in which you are now, or ever have been licensed to practice your profession.

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

11. NON-HCA Applicant Coursework

NOTE: This section pertains to applicants who do NOT possess a HCA Degree

If your degree was not in health care administration, complete this section in detail. List credit courses as set forth in R5-45-NHA, Section 3.1(c). PLEASE PROVIDE COURSE TITLE, COURSE NUMBER, THE COLLEGE OR UNIVERSITY WHERE YOU TOOK THE COURSE AND THE GRADE THAT YOU RECEIVED. Provide course descriptions for any clarification. ***PLEASE NOTE:*** *One course may satisfy up to two (2) domains of practice. Courses must be 3 or 5 credits.*

Domain of Practice

1. Residential Care Management in Nursing Homes

Course Title

Course Number

College or University

Credit and Grade

2. Personnel Management

Course Title

Course Number

College or University

Credit and Grade

3. Financial Management of Nursing Homes

Course Title

Course Number

College or University

Credit and Grade

4. Environmental Management of Nursing Homes

Course Title

Course Number

College or University

Credit and Grade

5. Governance and Management of Nursing Homes

Course Title

Course Number

College or University

Credit and Grade

Comments:

12. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

13. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined, or are formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, a separate sheet of paper.

14. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

I, _____, being first duly sworn, depose and say that I the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Nursing Home Administrator in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform HEALTH of any change in the answers to these questions after this application and this affidavit is signed.

_____ Signature of Applicant

_____ Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

_____ Name of Notary (Print, Type or Stamp)

_____ Signature of Notary

_____ Notary No./Commission No.

_____ Commission Expiration Date (MM/DD/YY)

Notary Seal

15. Recent Photograph

Securely tape a current 2" x 3" photograph.

NO PHOTOCOPIES

ATTACH WITH CLEAR TAPE ONLY

Provide the date that the photograph was taken.

_____ Date of Photograph

Substitute forms are not acceptable, copy this form as needed.

Rhode Island Department of Health
Room 105, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-5888

Documentation of Three Hundred Fifty (350) Hours of Field Experience
(AIT Certification Form - Required for Examination and Endorsement Applicants Only)

Print/Type Applicant's Full Name	Social Security Number	Date of Birth 19

R5-45-NHA, "Rules and Regulations for Licensing of Nursing Home Administrators" - Section 3.0, "Qualifications for Licensure" - requires successful completion of a degree in a health-care related field from an accredited College or University ***and*** *requires satisfactory completion of a field experience of at least three hundred fifty (350) hours, within a twelve (12) month period, in a training capacity in a licensed nursing facility that shall include training in the following areas: Administration, Nursing, Activities Department, Social Services/Admissions, Human Resources, Rehabilitation Department, Medical/Patient Records, Business Office, Dietary Department, Environment/Maintenance and Housekeeping/Laundry. At the conclusion of the field experience, the administrator of the licensed nursing facilty where the field experience was performed must attest that the training included each area.*

I hereby attest that _____ has satisfactorily completed three hundred fifty (350) hours* of Field Experience in the following areas:

Number of Hours		Number of Hours		Number of Hours	
☐	**Administration**	☐	**Nursing**	☐	**Human Resources**
☐	**Activities Department**	☐	**Admissions**	☐	**Medical/Patient Records**
☐	**Dietary Department**	☐	**Environment/Maintenance**	☐	**Business Office**
☐	**Rehabilitation Department**	☐	**Social Services/Admissions**	☐	**Housekeeping/Laundry**

☐ **Other, Explain:** _____

☐ **Total number of hours in AIT Training Program**

Hours should be approximate. The weights accorded the six domains of practice per NAB:

16% Resident Care Management	*25% Financial Management*	*11% Environmental Management*
13% Personnel Management	*19% Regulatory Management*	*20% Organizational Management*

RI NHA Name _____ RI NHA License Number _____

RI NHA Signature _____ Date of Signature (MM/DD/YY) _____

RI Nursing Facility _____

The foregoing instrument was acknowledged before me this _____ day of

_____, 20_____, by _____,

who is personally known to me or has produced _____

as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp) _____ Signature of Notary _____

Notary Seal

Notary No/Commission No. _____ Commission Expiration Date (MM/DD/YY) _____

Substitute forms are not acceptable, copy this form as needed.

Rhode Island Department of Health
Room 105, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-5888

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as a Nursing Home Administrator in the State of Rhode Island. The Rhode Island Department of Health requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Department of Health.

Print/Type Full Name

Signature _____ Date _____

Previous Names Used

Social Security Number

Date of Birth

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE NURSING HOME ADMINISTRATOR BOARD

Nursing Home Administrator Program Completed:	Location:	Graduation Date:
Licensed by Examination? ☐ Yes ☐ No	Applicant has completed and passed the National Certification Exam: ☐ Yes ☐ No	
License Status: ☐ Active ☐ Inactive ☐ Lapsed	Original Date Issued:	Expiration Date:

Questions:

1. Has this licensee ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name

Title

Full Name and State of Licensing Board

Please Affix
Board Seal Here

Please return directly to HEALTH at the above address. Thank you for your prompt cooperation.