For Office Use Only	☐ $120

Application for Nursing Home Administrator Licensure

Iowa Department of Public Health/Bureau of Professional Licensure

PLEASE PRINT **Instructions are found on page 3**

1. _____ 2. _____
Last Name *First Name and Middle Name*

3. _____
Mailing Address

4. _____ 5. _____
City, State, Zip Code *E-Mail Address*

6. _____ 7. _____ 8. _____-_____-_____
Daytime Phone (Including Area Code) *Date of Birth* *Social Security Number**

9. ☐ Male ☐ Female 10. _____
Gender (optional question) ***If any of your documentation is in a name other than your current name, list the previous names of record***

The following questions must be answered. If you answer "Yes" to any of the next six questions, (1) attach a signed letter of explanation providing the details of the incident, (2) attach a copy of any court ordered evaluations, showing completion and recommendations, and (3) attach a copy of all official court documents regarding your conviction/malpractice suit, including final disposition and/or settlement. You must answer "Yes" even when a conviction or judgment has been deferred or expunged from your record.	
11. Been convicted, found guilty of or entered a plea of guilty or no contest to a felony or misdemeanor crime (Other than minor traffic violations with fines under $500)?	Yes No
12. Had any judgments or settlements paid on your behalf as a result of a malpractice suit or claim against you?	Yes No
13. Been investigated by a licensing, registration, or certification authority or organization; or had a licensing, registration, or certification authority or organization institute disciplinary action against you related to your professional practice? (If the investigation or action was instituted by this licensing board you may answer "NO" to this question).	Yes No
14. Been disciplined or sanctioned by any licensing, registration, or certification authority or organization related to your professional practice? (If this licensing board took the disciplinary action, you may answer "NO" to this question).	Yes No
15. Developed a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? (If you are currently a participant in the Impaired Practitioner Review Committee, you may answer "NO" to this question.)	Yes No
16. Been engaged in illegal or improper use of drugs or other chemical mood altering substances? (If you are currently a participant in the Impaired Practitioner Review Committee, you may answer "NO" to this question.)	Yes No

17. **Type of Application:** ☐ **Examination** ☐ **Endorsement**

Education

18. Highest level of education attained: ☐ Bachelors ☐ Masters ☐ Doctorate

Date degree was obtained _____

19. Type of degree:
☐ Health Care Administration/Mgmt. ☐ Health Services Administration/Mgmt. ☐ Nursing Home Administration
☐ Long Term Care Administration ☐ Other, title of degree: _____
[Requires completion of coursework required in 645 IAC 141.4(2).]

20. _____
Name of educational institution

21. **PRACTICUM** Applicants must complete 720 clock hours of long term health care practicum consisting of 80 hours in each of the nine areas listed below. [Practicum must comply with 645--IAC 141.4(1) or 141.4(2).]

REQUIRED PRACTICUM AREAS:

SOCIAL SERVICES
DIETARY
LEGAL ASPECTS & GOVERNMENT ORGANIZATIONS
NURSING
ENVIRONMENTAL SERVICES
ACTIVITIES/COMMUNITY RESOURCES
BUSINESS ADMINISTRATION
ADMINISTRATIVE ORGANIZATION
HUMAN RESOURCE MANAGEMENT

You must complete ONE of the following requirements:

a. I have completed the required 720 clock hours of long-term health care practicum. The practicum hours are listed on my transcripts. ☐ **Yes** ☐ **No**

b. The designated faculty of the academic program may verify the completion of long term health care practicum.

In accordance with the above referenced requirements the licensure applicant _____ has completed a prescribed long-term health care practicum. The practicum included at least 80 clock hours in each of the nine required areas listed. (total 720 hours)

_____ _____
Signature & Title of Designated Faculty Member *Date*

c. The school may waive up to 320 clock hours based on prior academic coursework or experience.

In accordance with the above referenced requirements the licensure applicant _____ has completed a long-term health care practicum. Partial credit was given for the previous academic coursework and/or experience, not to exceed 320 hours of the 720 hours of required practicum. The applicant has completed the equivalent of 80 clock hours in each of the nine required areas listed.

_____ _____
Signature & Title of Designated Faculty Member *Date*

d. Substitution of one year long term health care administration experience may be allowed at the discretion of the Board:

1. Requires official written employment verification. – See separate page –
2. Licensed Nursing Home Administrator Statement (required):

I hereby attest that the licensure applicant _____ has completed the equivalent of 80 clock hours in each of the nine practicum areas listed.

Completed By: _____ NHA License Number: _____ State:_____

Facility/Company: _____

Address: _____ *City/State* _____

_____ _____
Signature *Date*

NATIONAL EXAMINATION/OR NATIONAL CERTIFICATION

22. Have you passed the NAB Examination? ☐ Yes ☐ No
Your official scores must be sent from the exam service or the state in which you were originally licensed directly to this office. **OR**

Do you have certification as an administrator in good standing with the American College of Health Care Administrators? If yes, certificate date _____. (Submit a notarized copy)

23. Are you or have you ever been licensed, certified, or registered in another state? ☐ Yes ☐ No
If yes, list the two-letter postal code of the state(s) below:

_____ _____ _____ _____ _____

I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted herewith if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code, Chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

*This information is collected pursuant to Iowa Code Chapters 252J, 261 & 272C. Failure to provide mandatory information will result in license denial. Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13) and Iowa Code § 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

23. _____ _____

Applicant must sign here in ink *Date*

INSTRUCTIONS/CHECKLIST

To complete the application, answer each question completely in ink. The following is a list of the supporting documents and fees required for licensure. It is the applicant's responsibility to see that all required documents and fees reach the board office.

☐ **The non-refundable licensure fee is $120.** Check or money order made payable to the Iowa Board of Nursing Home Administrators.

☐ **Notarized copy** of certification as an administrator in good standing from the American College of Health Care Administrators

OR

☐ **Proof of passing the NAB examination** sent directly from the state board office or exam service to this office.

☐ **Official transcripts** with school seal and degree attained from professional school, sent directly to the office from the school.

☐ **Verification of Employment**, if applicable.

☐ Applicants who hold or have held a nursing home administrator license in any other state or country must submit an **official verification** of licensure status from each state or country where you have held a license. Verification must include issue date, expiration date, and any pending or past disciplinary action.

An applicant who has been denied licensure by the board may appeal the denial and request a hearing on the issues related to the licensure denial by serving a notice of appeal and request for hearing upon the board not more than 30 days following the date of mailing of the notification of licensure denial to the applicant. The request for hearing shall specifically delineate the facts to be contested at hearing. If you have any question contact 515/281-6959 or Email: tamara.hidlebaugh@idph.iowa.gov.

Mail the original completed application bearing signature in ink to:

Iowa Board of Nursing Home Administrators
Lucas State Office Building, 5th Floor
321 E. 12th Street
Des Moines, Iowa 50319-0075
www.idph.state.ia.us/licensure

When you are licensed, you will be able to view and print your licensure status. Go to www.licensediniowa.gov. Click on License Search, insert your name, and select your profession. Your license and wallet card will be mailed to you after Active status is posted.