MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BOARD OF NURSING HOME ADMINISTRATORS

APPLICATION FOR LICENSURE

RCAL

I. IDENTIFYING INFORMATION (PLEASE TYPE OR PRINT IN INK)

1. LAST NAME	FIRST	MIDDLE

2. ADDRESS - HOME	STREET	CITY	COUNTY	STATE	ZIP CODE
ADDRESS - BUSINESS	STREET	CITY	COUNTY	STATE	ZIP CODE

3. TELEPHONE NUMBER			4. EMAIL ADDRESS
HOME	BUSINESS	CELL	

5. SOCIAL SECURITY NUMBER	6. DATE OF BIRTH	7. PLACE OF BIRTH	CITY	STATE

II. RECIPROCITY INFORMATION

1. HAVE YOU EVER APPLIED FOR AN ADMINISTRATOR LICENSE IN THIS STATE, OR ANY OTHER STATE? ☐ YES ☐ NO
   IF YES, AND LICENSE **NOT** ISSUED, PLEASE EXPLAIN BELOW.
   ____
   IF YES, AND LICENSE ISSUED, COMPLETE THE FOLLOWING.

STATE	DATE OF LICENSURE	LICENSE NUMBER	STATUS (CURRENT, EXPIRED, ETC.)

III. OTHER PROFESSIONAL LICENSES

1. DO YOU NOW HOLD, OR HAVE YOU EVER HELD, A LICENSE FROM ANY OTHER PROFESSIONAL BOARD IN THIS OR ANY OTHER STATE? IF YES, COMPLETE THE FOLLOWING ☐ YES ☐ NO

STATE	TYPE OF LICENSE	LICENSE NO.	DATE ISSUED	STATUS

2. HAVE ANY OF YOUR PROFESSIONAL LICENSES LISTED ABOVE EVER BEEN DISCIPLINED? ☐ YES ☐ NO
   IF YES, EXPLAIN AND ATTACH A COPY OF ANY SETTLEMENT AGREEMENT, CONTRACT, ETC. THAT YOU ENTERED AT THE TIME OF THE DISCIPLINE.
   ____

IV. CRIMINAL RECORD

1. HAVE YOU EVER BEEN CHARGED WITH, ARRESTED FOR, OR CONVICTED OF AN OFFENSE INVOLVING THE OPERATION OF A NURSING HOME OR OTHER HEALTH CARE FACILITY? IF YES, ATTACH EXPLANATION. ☐ YES ☐ NO
2. HAVE YOU EVER BEEN CHARGED WITH, ARRESTED FOR, OR CONVICTED OF A CRIME, AN ESSENTIAL ELEMENT OF WHICH IS DISHONESTY, FRAUD OR MORAL TURPITUDE? IF YES, ATTACH EXPLANATION. ☐ YES ☐ NO
3. I HEREBY AUTHORIZE, BY MY SIGNATURE ON PAGE 4 OF THIS APPLICATION, THE BOARD OF NURSING HOME ADMINISTRATORS TO CONDUCT A RECORD CHECK ON ME, AN APPLICANT FOR LICENSURE, INCLUDING THE RELEASE OF ANY CLOSED RECORDS THAT MAY BE RELEVANT TO CHAPTER 344., RSMo, FOR THE PURPOSE OF CONSIDERING MY QUALIFICATIONS FOR LICENSURE (INCLUDING ARRESTS, CHARGES, INDICTMENTS AND CONVICTIONS). IF NO, PLEASE ATTACH EXPLANATION ☐ YES ☐ NO

____

HEIGHT	ATTACH RECENT PHOTOGRAPH HERE
WEIGHT	
COLOR OF HAIR	
EYES	

BOARD OF NURSING HOME ADMINISTRATORS

APPLICATION FOR LICENSURE – CONTINUED

V. EDUCATION RECORD

1. ARE YOU A HIGH SCHOOL GRADUATE, OR HAVE YOU BEEN AWARDED A GED CERTIFICATE? ☐ YES ☐ NO
2. LIST BELOW EDUCATION BEYOND HIGH SCHOOL

SCHOOL NAME AND ADDRESS	COURSE OF STUDY	YEARS ATTENDED FROM TO	DID YOU GRADUATE?	LIST DIPLOMA OR DEGREE
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	

VI. EMPLOYMENT HISTORY

1. IF YOU HAVE EVER BEEN DISMISSED FROM A POSITION, PLEASE EXPLAIN GIVING DATE, EMPLOYER AND CIRCUMSTANCES.

2. LIST **ALL** PRESENT AND PAST EMPLOYMENT, BEGINNING WITH YOUR MOST RECENT POSITION.
   IF ADDITIONAL SPACE IS NEEDED, PLEASE MAKE AN ADDENDUM.
   PLEASE FEEL FREE TO MAKE COPIES OF PAGE 3 IF ADDITIONAL SPACE IS NEEDED.

1. NAME AND ADDRESS OF EMPLOYER

TYPE OF BUSINESS

MAY THE MISSOURI BOARD OF NURSING HOME ADMINISTRATORS CONTACT THIS EMPLOYER?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN. ____

EMPLOYER TELEPHONE NUMBER

POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR
	MO.	YR.	MO.	YR.	

LIST **DUTIES** IN EACH POSITION TITLE LISTED ABOVE AND IF THE POSITION WAS FULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.

		NUMBER OF HOURS EACH WEEK
1.	☐ FULL-TIME ☐ PART-TIME	
2.	☐ FULL-TIME ☐ PART-TIME	
3.	☐ FULL-TIME ☐ PART-TIME	

APPLICATION FOR LICENSURE – CONTINUED

2. NAME AND ADDRESS OF EMPLOYER

TYPE OF BUSINESS

MAY THE MISSOURI BOARD OF NURSING HOME ADMINISTRATORS CONTACT THIS EMPLOYER?

☐ YES ☐ NO IF NO, PLEASE EXPLAIN. ______________________________

EMPLOYER TELEPHONE NUMBER

POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR
	MO.	YR.	MO.	YR.	

LIST **DUTIES** IN EACH POSITION TITLE LISTED ABOVE AND IF THE POSITION WAS FULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.

1.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK
2.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK
3.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK

3. NAME AND ADDRESS OF EMPLOYER

TYPE OF BUSINESS

MAY THE MISSOURI BOARD OF NURSING HOME ADMINISTRATORS CONTACT THIS EMPLOYER?

☐ YES ☐ NO IF NO, PLEASE EXPLAIN. ______________________________

EMPLOYER TELEPHONE NUMBER

POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR
	MO.	YR.	MO.	YR.	

LIST **DUTIES** IN EACH POSITION TITLE LISTED ABOVE AND IF THE POSITION WAS FULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.

1.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK
2.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK
3.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK

4. NAME AND ADDRESS OF EMPLOYER

TYPE OF BUSINESS

MAY THE MISSOURI BOARD OF NURSING HOME ADMINISTRATORS CONTACT THIS EMPLOYER?

☐ YES ☐ NO IF NO, PLEASE EXPLAIN. ______________________________

EMPLOYER TELEPHONE NUMBER

POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR
	MO.	YR.	MO.	YR.	

LIST **DUTIES** IN EACH POSITION TITLE LISTED ABOVE AND IF THE POSITION WAS FULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.

1.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK
2.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK
3.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK

PLEASE FEEL FREE TO MAKE COPIES OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED.

APPLICATION FOR LICENSURE – CONTINUED

5. NAME AND ADDRESS OF EMPLOYER					TYPE OF BUSINESS
MAY THE MISSOURI BOARD OF NURSING HOME ADMINISTRATORS CONTACT THIS EMPLOYER? ☐ YES ☐ NO IF NO, PLEASE EXPLAIN. ______					EMPLOYER TELEPHONE NUMBER
POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR
	MO.	YR.	MO.	YR.	

LIST **DUTIES** IN EACH POSITION TITLE LISTED ABOVE AND IF THE POSITION WAS FULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.

1.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK
2.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK
3.	☐ FULL-TIME ☐ PART-TIME	NUMBER OF HOURS EACH WEEK

VII. GENERAL

1. LONG TERM CARE FACILITY AFFILIATION (IF ANY, AFFILIATION MEANS TO OWN, PARTNER, OR ANY FINANCIAL STAKE IN THE OPERATION OF A FACILITY.)

NAME OF FACILITY		STREET ADDRESS	
CITY	STATE	COUNTY	ZIP CODE
BED CAPACITY	LICENSED BY MO. DIVISION OF REGULATION AND LICENSURE? ☐ YES ☐ NO ________LEVEL OF CARE	ADMINISTRATOR	

2. YOUR NAME AS YOU WISH IT TO APPEAR ON LICENSE

3. **PLEASE REFER TO THE INSTRUCTION SHEET POSTED ON THE WEBSITE AT WWW.HEALTH.MO.GOV/INFORMATION/BOARDS/BNHA WHEN COMPLETING THE APPLICATION.**

ALL CORRESPONDENCE WILL BE ADDRESSED TO YOUR HOME UNLESS YOU NOTIFY US DIFFERENTLY. YOU ARE REQUIRED TO NOTIFY THIS OFFICE OF ANY CHANGE OF HOME OR BUSINESS CONTACT INFORMATION WITHIN 21 DAYS OF THE CHANGE 19 CSR 73-2.130.

I hereby affirm under the penalty of perjury, that all information contained in this application and all supporting documents are true and correct to the best of my knowledge and belief. I understand that falsification of information may constitute grounds to deny licensure and to discipline my license pursuant to Section 344.050, RSMo.

SIGNATURE	DATE

PLEASE MAIL ALL DOCUMENTS AND FEE TO THE FOLLOWING ADDRESS:

Missouri Department of Health and Senior Services
Board of Nursing Home Administrators
Fee Receipts
P.O. Box 570
Jefferson City, MO 65102