



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 BOARD OF NURSING HOME ADMINISTRATORS
APPLICATION FOR LICENSURE

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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 YES NO
 ATTACH EXPLANATION

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
			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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.					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
2.					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
3.					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK

BOARD OF NURSING HOME ADMINISTRATORS
APPLICATION FOR LICENSURE – CONTINUED

2. NAME AND ADDRESS OF EMPLOYER					TYPE OF BUSINESS	
MAY THE MISSOURI BOARD OF NURSING HOME ADMINISTRATORS CONTACT THIS EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE EXPLAIN. _____					EMPLOYER TELEPHONE NUMBER	
POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR	
	MO.	YR.	MO.	YR.		
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1. _____					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
2. _____					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
3. _____					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK

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1. _____					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
2. _____					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
3. _____					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE EXPLAIN. _____					EMPLOYER TELEPHONE NUMBER	
POSITION TITLE(S)	FROM		TO		NAME AND TITLE OF IMMEDIATE SUPERVISOR	
	MO.	YR.	MO.	YR.		
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1. _____					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
2. _____					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK
3. _____					<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	NUMBER OF HOURS EACH WEEK

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

