



Maryland Board of Examiners of Nursing Home Administrators

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Application for PROVISIONAL Nursing Home Administrator License

This application is for nonlicensed individuals who have been appointed under § 9-301(b)(2) of the Health Occupations Article of the Annotated Code of Maryland to serve as interim nursing home administrators in Maryland nursing home facilities. Please fax or scan and e-mail this application along with all required documentation. The provisional license is not equivalent to a regular Maryland nursing home administrator license and does not require the identical criteria necessary for licensure. The following items should accompany your application (incomplete application packages will result in a delay of processing your provisional license):

1. An official letter of verification from the owner or other appropriate authority of the nursing home facility in which you have been appointed to serve as the nonlicensed interim nursing home administrator of record. The letter should be on official letterhead and include the nursing home authority's name and title, the name and physical address of the facility, the reason why the facility is seeking to appoint a nonlicensed interim administrator, and the **specific start and end dates the facility will have you serving as its nonlicensed interim administrator of record. NOTE: the standard provisional licensure period is limited to a maximum 90 days.**
2. If you are currently employed, an official letter of verification on letterhead from the human resources department that indicates your current job title, job responsibilities, and dates of employment with the organization.
3. If you are a licensed health care professional, a copy of your current license.
4. Your current resume.

PERSONAL INFORMATION

| | |
|------------------------------------------------------------------|--|
| Name (Last, First, Middle Initial) ¹ | |
| Maiden Name (If Applicable) | |
| Home Street Address | |
| Home City, State, Zip | |
| Home Telephone | |
| Work Telephone | |
| Cell Phone | |
| Email Address | |
| Social Security Number | |
| Date of Birth | |
| Your name exactly as it should appear on the provisional license | |

¹ If your name has changed since you obtained a previously issued license, or if your name is different on any of your supporting documentation, you must provide a copy of the legal document verifying the name change.

FACILITY INFORMATION

| | |
|-----------------------------------------------------------------------------------------|--|
| Name of Nursing Facility | |
| Nursing Facility Street Address | |
| Nursing Facility City, State, Zip | |
| Nursing Facility Telephone | |
| Number of Beds | |
| Intended Start and End Dates to Serve as Nonlicensed Interim Nursing Home Administrator | |
| Name of Immediate Supervisor | |
| Immediate Supervisor's Title | |
| Immediate Supervisor's Phone | |
| Immediate Supervisor's E-mail | |

GENDER AND RACE/ETHNICITY

To further its commitment to equal opportunity, the Board of Examiners of Nursing Home Administrators requests applicants to provide, *voluntarily*, the following information. This information will be used for statistical purposes only by authorized personnel:

GENDER: Male Female

RACE/ETHNIC IDENTIFICATION – PLEASE CHECK ALL THAT APPLY

Are you of Hispanic or Latino origin? Yes ___ No ___ (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

1. ___ American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)
2. ___ Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
3. ___ Black or African American (A person having origins in any of the black racial groups of Africa.)
4. ___ Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
5. ___ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

EDUCATION

| University | Field of Study | Degree | Date Awarded |
|------------|----------------|--------|--------------|
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LICENSURE AND HISTORY INFORMATION

Do you hold, or have you in the past, held a professional license (e.g., Registered Nurse)? If yes, list the following information here:

| | |
|--------------------------------|--|
| 1. State | |
| License Number/Expiration Date | |
| 2. State | |
| License Number/Expiration Date | |

WORK HISTORY

Current/Most Recent Employment:

| | |
|----------------------------------|--|
| Name of Business/Institution | |
| Street Address | |
| City, State, Zip | |
| Telephone Number | |
| Your Job Title | |
| Name and Title of Supervisor | |
| Dates of Employment | |
| Description of Duties Performed: | |
| | |

Next Most Recent Employment:

| | |
|----------------------------------|--|
| Name of Business/Institution | |
| Street Address | |
| City, State, Zip | |
| Telephone Number | |
| Your Job Title | |
| Name and Title of Supervisor | |
| Dates of Employment | |
| Description of Duties Performed: | |
| | |

Next Most Recent Employment:

| | |
|----------------------------------|--|
| Name of Business/Institution | |
| Street Address | |
| City, State, Zip | |
| Telephone Number | |
| Your Job Title | |
| Name and Title of Supervisor | |
| Dates of Employment | |
| Description of Duties Performed: | |
| | |

CHARACTER AND FITNESS

Please answer each of the following questions by putting a check (✓) in the appropriate box on the right. You must answer each question with a “Yes” or “No” response as no other response is acceptable. All “Yes” answers **MUST** be explained in detail in a separate **SIGNED** and **NOTARIZED** affidavit. The affidavit should include all relevant dates and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. Have you ever had any application for any professional license refused or denied by any licensing authority? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Have you ever been placed on probation, restrictions, suspension, revocation, modification, allowed to resign, requested to leave temporarily or permanently, or otherwise acted against by any professional training program prior to completing the training? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Have you ever surrendered a professional license? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Have you ever had any professional license suspended or revoked? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Have you ever been the subject of disciplinary action by any licensing agency with regard to any professional license? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. To your knowledge have any unresolved or pending complaints ever been filed against you with any licensing agency, association, or licensed health care facility? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7. Has your employment or contract with any health care related entity or employer ever been terminated for disciplinary reasons? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. Have you ever resigned from employment or from a contract with any health care related entity or employer for any disciplinary related reasons or while under investigation for disciplinary related reasons? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 9. Have you ever pled guilty or nolo contendere, been convicted of, or received probation before judgment for any criminal offense (excluding minor traffic violations)? If “Yes”, in addition to the affidavit, attach a certified copy of the court records regarding your conviction, the nature of the offense, date of discharge, if applicable, as well as a statement from the probation or parole officer. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 10. Are there any current or pending criminal charges against you in any court of law? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 11. Have you ever been arrested or charged with a criminal offense excluding a minor traffic violation? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 12. Are you now being treated or have you in the last 5 years been treated for a drug or alcohol addiction or participated in a rehabilitation program? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 13. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions in the practice of a nursing home administrator, including disease or condition generally regarded as chronic by the medical community, i.e. (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 14. Have you ever been named as a defendant to a civil suit related to your profession? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 15. Have you ever been court martialled or discharged other than honorably from the armed service? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

CRIMINAL HISTORY RECORDS CHECK

Per § 9-302.1 of the Annotated Code of Maryland, you must undergo a criminal history records check in order to be granted a Nursing Home Administrator License by the Board, and this is inclusive of Provisional Licenses. If an applicant is currently licensed by another State of Maryland Health Occupations board and has previously undergone a criminal history records check with that board, he/she is responsible for providing this Board with a verifiable copy of this criminal history records check. Until the Board Office receives notification of your criminal history records check, you will not be able to receive your license.

When you are preparing to have your criminal background check processed, please e-mail our Deputy Director/Licensing Coordinator, Andrea Hill, at andrea.hill@maryland.gov or Executive Director, Ciara J. Lee, at ciaraj.lee1@maryland.gov to request the Board's authorization number and its "Originating Agency Identifier" number ("ORI" number). **You will need these two numbers to proceed with your background check being processed.** The Department of Public Safety and Correctional Services website (which contains a detailed list of various processing locations throughout the state) is as follows: <http://dpscs.maryland.gov/publicservs/fingerprint.shtml>

For your convenience, the Criminal History Livescan Pre-Registration Application will be available on the Board's website at the "Forms" section under Quick Links for you to print out to take with you for processing.

CRIMINAL HISTORY CHECKS FOR OUT OF STATE APPLICANTS

1. You may write CJIS-Central Repository P.O. Box 32708, Pikesville, Maryland 21282-2708, or call the Central Repository in Baltimore City at 410-764-4501 or toll free number 1-888-795-0011 to request a fingerprint card.
2. You may mail the fingerprint card and associated fee to CJIS-Central Repository P.O. Box 32708 Pikesville Maryland 21282-2708, or overnight the fingerprint card to 6776 Reisterstown Road, Suite 102, Baltimore Maryland 21215.
3. Please include a **check** made out to "CJIS Central Repository". Only checks are accepted from out of state applicants.

You may expect a response in 10 - 15 business days.

AFFIDAVIT OF APPLICANT

I authorize the Maryland Board of Examiners of Nursing Home Administrators (“the Board”) to investigate any area it deems necessary. Should I furnish any false information on the application, I hereby agree that such an act shall constitute cause for the denial of my application for licensure or the suspension or revocation of my license. I agree that it is my duty as the applicant to provide supplemental information to the Board if there is any material change after submission of the application. I agree that no liability attends to the Board for its use of this material so long as it relates to licensure.

I understand that, as an appointed interim nursing home administrator, I am not permitted to simultaneously hold or function in ANY other position in the nursing home facility (e.g., Director of Nursing) while I am holding the position of interim nursing home administrator. I understand that my provisional license will immediately be revoked by the Board if I am found to have violated this restriction.

I understand that I must undergo a full criminal background check, which will be performed by an outside agency, and that all fees associated with the background check are my responsibility. I understand that any unsatisfactory criminal background check results may result in the Board’s immediate revocation of my provisional license and may preclude me from being eligible to be licensed by the Board in the future.

Signature of Applicant

Date
