State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

Official Use Only
Number: _____
Date Approved/Denied: _____
Approved/Denied By: _____

Health Facility Administrator

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

Please Select ONE:

☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
☐ I am a foreign national not physically present in the United States.
☐ None of the above, please explain: _____

Driver License or State ID Card: _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of authorization to work in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: _____ Date: _____

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1.	☐ Yes	☐ No	Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
2.	☐ Yes	☐ No	Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any professional licensing agency or criminal or administrative jurisdiction?
3.	☐ Yes	☐ No	Are you currently under investigation or is any disciplinary action pending against you now by any *local, state or federal licensing, enforcement or regulatory agency?*
4.	☐ Yes	☐ No	Have you ever been declared by any court to be incompetent by reason of mental defect or disease and not restored?
5.	☐ Yes	☐ No	Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
6.	☐ Yes	☐ No	Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug or alcohol use or abuse within the past five (5) years?
7.	☐ Yes	☐ No	Are you currently using or have you recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under applicable state or federal laws?
8.	☐ Yes	☐ No	Have you ever unlawfully used any drugs for which you have not successfully completed, or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?
9.	☐ Yes	☐ No	Do you currently have any criminal action pending?*
10.	☐ Yes	☐ No	Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? *
11.	☐ Yes	☐ No	Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?*
12.	☐ Yes	☐ No	Have you ever been incarcerated for any reason in any correctional facility (*domestic or foreign*) in any jurisdiction or on probation/parole in any jurisdiction?*

***NOTE:* Charges that were later dismissed and motor vehicle offenses such as driving while impaired or intoxicated must be disclosed; however, minor traffic offenses such as parking or speeding violations need not be listed.**

If you answered **"Yes"** to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

If you answered **"Yes"** to Questions **9,10,11** or **12** you must submit the following for **EACH** and **EVERY** incident:

- Personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

QUALIFYING QUESTIONNAIRE

PROFESSIONAL LICENSES

List all other licenses, registrations or certification issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:

☐ Yes ☐ No a hospital or health care facility
☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
☐ Yes ☐ No malpractice insurance coverage
☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www/npdb.hrsa.gov.*

If you answered **"Yes"** to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

Affidavit of Completion of AIT Preceptorship

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

EMPLOYMENT INFORMATION

To be completed by the Preceptor.

Name of Preceptor: _____ **License Number:** _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number: _____ **Email:** _____

Dates of Employment/Supervision: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

Total Hours Supervised Practice: _____

Is the applicant currently employed with the facility? ☐ Yes ☐ No

If no, is the applicant re-hirable? ☐ Yes ☐ No, Please explain: _____

I certify that I am a licensed health facility administrator in good standing and have been the preceptor for the AIT applicant named above, and that I have personally supervised the AIT training program for the applicant for licensure as a health facility administrator. I further certify that this supervision was on a personal basis and that the AIT under my supervision fulfilled the AIT preceptorship as outlined in Utah Administrative Rule R156-15-307.

Signature of Supervisor: _____ **Date:** _____

Verification of Experience

Each supervisor must complete a separate form. The hours of all forms must total 8,000.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

EMPLOYMENT INFORMATION

To be completed by the Supervisor.

Name of Establishment: _____

Name of Supervisor: _____ **License Number:** _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number: _____ **Email:** _____

Dates of Employment/Supervision: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

How many hours per week did the applicant work? _____ ☐ Part time ☐ Full Time

Total Hours Supervised Practice: _____

Total Hours Managerial Experience: _____

Is the applicant currently employed with the facility? ☐ Yes ☐ No

If no, is the applicant re-hirable? ☐ Yes ☐ No, Please explain: _____

I do hereby certify that the applicant for licensure as health facility administrator has successfully completed the above hours of supervised experience as a W-2 employee of the facility listed. I certify that the experience supervised meets the requirements outlined in R156-15-307.

I further certify that the applicant is qualified and competent to practice as a licensed health facility administrator.

Signature of Supervisor: _____ **Date:** _____

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

The following items are required to complete your application:

$120.00 non-refundable application-processing fee, made payable to "DOPL".

Supporting documentation for any "yes" answers provided on the either of the qualifying questionnaires. See pages 2 and 3 of the application for more information.

Official verification of passing the National Association of Boards of Examiners for Nursing Home Administrators (NAB) Examination with a minimum score of 113.

Affidavit of Completion of AIT Preceptorship. *(See page 4 of this application.)*

Documentation of meeting one of the following education and experience options:

- Official transcripts documenting a minimum of a Bachelor's degree from an accredited school that may include 500 hours in an internship, practicum or outside study program in health care or facility administration. ***NOTE:*** Transcripts are considered "official" when they are sent directly from the school to DOPL or sealed in an envelope bearing the school's stamp/seal on the envelope flap.
  OR
- Original "Verification of Experience" documenting a minimum of 8,000 hours experience, at least 4,000 shall be in a supervisory role. *(See page 5 of this application.)*
  OR
- Official verification of an active health facility administrator (or similar) license from another state with equivalent education and experience requirements.

**NOTE: If you previously submitted these documents with your "Request for Authorization to Test", you do not need to submit them again.*

TEMPORARY LICENSURE DUE TO UNEXPECTED CIRCUMSTANCES

A temporary license may be issued without examination to a person who meets all other requirements established by statute and by rule to fill an *immediate, unexpected* vacancy. It is the applicant's responsibility to prove the vacancy was unexpected. The temporary license is valid for a single six month period, and cannot be extended. To request a temporary license under these limited circumstances, you must contact the Division directly.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Occupational and Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Occupational and Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741