Washington State Department of Health

# Nursing Home Administrator Expired License Activation Application Packet

## Contents:



## Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360-236-4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

## In order to process your request:

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health
PO Box 1099
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Board of Nursing Home Administrators
Credentialing
PO Box 47877
Olympia, WA 98504-7877

## Contact us:

360-236-4700

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# Application Instructions Checklist

You will be notified in writing if further documentation is required. To ensure you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ **Pay** Late Renewal Penalty Fee.
- ☐ **Pay** Current Renewal Fee.
- ☐ **Pay** Expired License Reissuance Fee.
  **All fees are non-refundable.** You can check the online **fee page** for current fees.
- ☐ **1. Demographic Information.**
  **Social Security Number:** You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

  **National Provider Identifier Number (NPI)**: The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

  **Legal Name:** List your full name: first, middle, and last.

  **Definition of legal name:** "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

  **Birth date:** Provide the month, day, and year of your birth.

  **Birth place:** Provide the city, state and country where you were born.

  **Address:** List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

  **Phone, Fax and Cell Numbers:** Enter your phone, fax and cell numbers, if you have them.

  **Email:** Enter your email address, if you have one.

  **Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Other License, Certification, or Registration.** List **all** credentials you have held since last being credentialed in Washington State. List in date order, most current first. Include your last active credential in Washington State. Attach additional pages if you need more space.

☐ **3. Professional Experience.** List in date order, most recent to later, all your professional work experience since your Washington State credential expired. Attach additional pages if you need more space.

☐ **4. AIDS Education and Training Attestation:** Required by **WAC 246-12-040**.

☐ **5. Disciplinary Action Attestation:** Required by **WAC 246-12-040**.

☐ **6. Continuing Education Attestation:** Required by **WAC 246-12-040**.

☐ **7. Applicant's Attestation:** Required to be both signed and dated in order to process the application.

# Additional Information

**For licenses expired more than one year but less than five years:**

- Submit documentation of completion of 36 hours of continuing education for the two-year period immediately preceding your request for reactivation.
- Continuing education courses must meet the conditions established in **WAC 246-843-130**.

**For licenses expired five years or more:**

- Submit documentation of completion of 36 hours of continuing education for the two-year period immediately preceding your request for reactivation.
- Continuing education courses must meet the conditions established in **WAC 246-843-130**.
- Submit verification of active practice in another jurisdiction **or successfully complete the current licensing examination.**

Washington State Department of Health

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**Revenue 0264010000**

# Nursing Home Administrator
# Expired License Activation Application

Please print clearly in blue or black ink. Follow all instructions provided. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

## 1. Demographic Information

| **Social Security Number (SSN)**<br>(If you do not have a SSN, see instructions) | **National Provider Identifier Number (NPI)**<br>(Enter 10 digit number) | ☐ Male<br>☐ Female |
|---|---|---|

Name First Middle Last

| Birth date (mm/dd/yyyy) | **Place of birth** | | |
|---|---|---|---|
| | City | State | Country |

Address

| City | State | Zip Code | County |
|---|---|---|---|

Country

| Phone (enter 10 digit #) | Fax (enter 10 digit #) | Cell (enter 10 digit #) |
|---|---|---|

Email address

Mailing address if different from above address of record

| City | State | Zip Code | County |
|---|---|---|---|

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

## 2. Other License, Certification, or Registration

List **all** credentials you have held since last being licensed in Washington State. List in date order, most recent to later. Include your last active credential in Washington State.

| State/Jurisdiction | Profession | Credential | | | Method of Credentialing | Currently in force | |
|---|---|---|---|---|---|---|---|
| | | Type | Number | Yr Issued | | No | Yes |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## 3. Professional Experience

List in date order, all your professional work experience since your Washington State credential expired.

| Type of experience of practice and location | Start (mm/yyyy) | End (mm/yyyy) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## 4. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

| Applicant's Initials | Date |
|---|---|
| | |

## 5. Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

| Applicant's Initials | Date |
|---|---|
| | |

## 6. Continuing Education/Continuing Competency Attestation

I certify that I have met all continuing education and competency requirements for the past two years.
I am enclosing documentation on all classes attended/claimed.

| Applicant's Initials | Date |
|---|---|
| | |

## 7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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Washington State Department of Health
Board of Nursing Home Administrators
Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

# Out-of-State Credential Verification

**To applicant:** Complete top portion in full and forward to each state in which you hold or have held a credential as a Nursing Home Administrator. Contact each state for information on a fee for this service.

| Name (Last, First, Middle Initial) | | |
|---|---|---|
| Street Address | | |
| City | State | Zip Code |
| Daytime Phone (enter 10 digit #) | | |

I authorize the release of the information requested below to the Washington State Board of Nursing Home Administrators.

Applicants Signature_____ Date_____

**To state board:** The above individual is applying for licensure as a Nursing Home Administrator in Washington State. Please complete the following information and mail to the Washington State Board of Nursing Home Administrators at the address above. Thank you for your cooperation.

| Credential Number | State | Date Issued | Expiration Date |
|---|---|---|---|
| | | | |

If this is not the state of original license, was license through reciprocity/endorsement? ☐ Yes ☐ No

If yes, from what state?

Status of License: ☐ Active ☐ Inactive ☐ Expired ☐ Other (Specify)

Exam: ☐ NAB ☐ Other (specify)_____

Exam Date _____ Exam State _____ NAB Score: Raw _____

Scale_____ Exam Date _____ Exam State _____

Was an AIT Program successfully completed? ☐ Yes ☐ No

If yes, please explain _____

_____

Is there any investigation or disciplinary action pending? ☐ Yes ☐ No

If yes, please explain _____

_____

Individual completing form_____ Title_____

Signature _____ Date _____

Phone (enter 10 digit #)_____ City_____ State _____

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# RCW/WAC and Online Web site Links

## RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Nursing Home Administrator Laws, RCW 18.52

Nursing Home Administrator Rules, WAC 246-843

## On-Line

AIDS Training Resources, Reference Page

Board of Nursing Home Administrators, Web Page