

**APPLICATION FOR RECIPROCAL LICENSE  
NURSING HOME ADMINISTRATOR**

**WEST VIRGINIA NURSING HOME  
ADMINISTRATORS LICENSING BOARD**

**P. O. BOX 522**

**WINFIELD, WV 25213**

**Physical Address: 13049 Winfield Rd. Winfield, WV 25213**

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**Surname**

**Given Name**

**Middle/Maiden Name**

## **INSTRUCTIONS**

The application for reciprocal license is made up of six (6) major parts. The applicant himself furnishes the information that is requested in Parts I – IV. Parts V and VI are separate, single pages which are to be detached from back of form and given by the applicant to his personal physician and to two persons of his choice who will serve as his character references.

When Parts I – IV (Part IV requires notarization of the application) have been completed, they with the check and photograph attached, should be mailed immediately to:

WEST VIRGINIA NURSING HOME ADMINISTRATORS LICENSING BOARD  
P. O. Box 522  
Winfield, WV 25213

Applications will not be presented for consideration until all required materials have been received and the application is considered complete.

TO INSURE COMPLIANCE WITH FEDERAL LAW, THE NURSING HOME ADMINISTRATORS LICENSING BOARD IS OBLIGATED TO INFORM EACH APPLICANT OR LICENSEE THAT REPORTING OF HIS/HER SOCIAL SECURITY NUMBER IS MANDATORY IN ORDER FOR THE BOARD TO COMPLY WITH THE REQUIREMENTS OF THE NATIONAL PRACTITIONER DATA BANK (NPDB). I UNDERSTAND THAT ANY FINAL DISCIPLINARY ACTION TAKEN AGAINST MY NURSING HOME ADMINISTRATOR'S LICENSE WILL BE REPORTED TO THE (NPDB). I ALSO UNDERSTAND THAT MY SOCIAL SECURITY NUMBER WILL BE USED IN SUCH REPORTING.

TO THE WEST VIRGINIA NURSING HOME ADMINISTRATORS LICENSING BOARD:

I, \_\_\_\_\_, hereby make application to be registered as a nursing home administrator pursuant to Chapter 16, Article 5D, Code of West Virginia, 1931, as amended.

## **SPECIAL INSTRUCTIONS FOR THE INDIVIDUAL PARTS OF THE APPLICATION**

### **Part I – PERSONAL DATA**

- (1) Enter your social security number.
- (2) “full Name of Applicant” – Enter last name (surname) first, as indicated on the form. Female applicants should enter their names as: Doe, Mary Smith, not as, Doe, Mrs. John E.
- (3) At the end of part I, list the names of your physician and the two persons whom you have selected to be your character references.
- (4) **Attach a certified copy of your Birth Certificate** to Part I of Application.
- (5) It is mandatory for applicants to complete a criminal record history card when applying for the following applications: Licensure by Examination, Administrator-in-training and Reciprocity. Go to [www.Llenrollment.com](http://www.Llenrollment.com) – follow instructions for completion and submission of a criminal record history check for WV and the FBI. If you are an out-of-state resident, submit a state background check for the state in which you reside.

### **PART II – EDUCATION**

- (1) Limit the information given in “Additional Education” and Special Qualifications and Activities” sections to those events, which occurred within the past ten (10) years.
- (2) Please attach photocopies of all licenses and professional certificates.
- (3) It is the applicant’s responsibility to have certified transcripts of college work forwarded directly by the college to the Board Office.

### **PART III – WORK HISTORY**

- (1) List your present employment in the first section on the page. Then, in reverse chronological order, account for your “Work History” during the past ten (10) years.
- (2) In describing your job duties, indicate the nature of work performed not the details of the tasks.

### **PART IV – AFFIDAVIT OF APPLICANT**

- (1) Be sure your application is notarized.
- (2) Be sure your photograph is attached.

- (3) Be sure you have enclosed a certified check or money order for the Six Hundred-Dollar (\$600.00) Fee. Make check payable to the WV NHALB.
- (4) Read “Important Notes” and heed their content.

#### **PART V – MEDICAL CERTIFICATION**

- (1) Enter your name and social security number in space provided.
- (2) Give Part V to your personal physician.
- (3) Ask your physician to complete the form and then mail it directly to the Board Office.
- (4) It is your responsibility to see that your physician completes the form promptly and forward it directly to the office of the Board before the filing deadline.

#### **PART VI – CERTIFICATE OF MORAL CHARACTER**

- (1) Enter your name and social security number in space provided.
- (2) There are two copies of Part VI. Give one copy to each of the two persons who is to serve as a character reference for you. As stated at the top of Part VI, these persons must be unrelated to you and not in your employment.
- (3) Ask each person to complete his copy of the form and to mail it directly to the Office of the West Virginia Nursing Home Administrators Licensing Board.
- (4) It is your responsibility to see that your character references complete their forms promptly and forward them directly to the Board Office before the filing deadline.

**SUGGESTION:** Give a pre-addressed, stamped envelope to your physician and to your character references for their use in mailing the certificate forms directly to the Board Office.

PURSUANT TO W. VA. CODE § 48A-5A-5(c) EACH APPLICANT FOR LICENSE MUST ANSWER THE FOLLOWING QUESTIONS AND CERTIFY, UNDER PENALTY OF FALSE SWEARING, THAT THESE ANSWERS ARE TRUE AND CORRECT.

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Do you have a child support obligation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If the answer to question 1, above, is yes, are you in arrearage?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If the answer to question 2, above is yes, does your arrearage equal or exceed the amount of child support payable for six (6) months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you the subject of a child support related subpoena or warrant?  | <input type="checkbox"/> | <input type="checkbox"/> |

IF YOU MAKE A FALSE STATEMENT CONCERNING ANY QUESTION ON THIS APPLICATION, YOU MAY BE SUBJECT TO DISCIPLINARY ACTION INCLUDING, BUT NOT LIMITED TO, IMMEDIATE REVOCATION OR SUSPENSION OF YOUR LICENSE.

**APPLICANT**

I, \_\_\_\_\_ do hereby certify, under penalties of perjury and false swearing, that the above questions are true and correct to the best of my knowledge.

**APPLICATION FOR RECIPROCAL LICENSE**

Nursing Home Administrator

(Please type or print. Answer All Questions In Full)

Part I – Personal Data

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Full Name of Applicant – Surname – Given Name- Middle Maiden Name

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

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Birthdate Mo.Day.Yr. Sex M  F  Social Security Number\_\_\_\_/\_\_\_\_/\_\_\_\_/

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Residence Address – St. No. Name or RFD – City – State – Zip Code

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Place of Birth – City – Country – State or Foreign Country

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E-mail Address

Home Ph. Number

Citizenship - Native Born\_\_\_\_Naturalized\_\_\_\_ ( ) \_\_\_\_-\_\_\_\_

If Naturalized, Give the following information about Certificate or Naturalization:

Certificate No.\_\_\_\_Date Issued\_\_\_\_ Place where Issued\_\_\_\_

Answer each of the following questions by checking either “Yes or No”:

\_\_\_Yes \_\_\_No - Have you ever been convicted of a felony?

\_\_\_Yes \_\_\_No – Is there any criminal charge, other than a traffic violation now or pending against you?

\_\_\_Yes \_\_\_No – Are you licensed as a nursing home administrator in any other State?

If “yes” enter in Part II – (D) information for all States in which you are Licensed.

\_\_\_Yes\_\_\_No – Has any application for a nursing home administrator’s license ever been denied to you?

\_\_\_Yes\_\_\_No – Has your nursing home administrator’s license ever been suspended or revoked?

If your answer to any of the above questions is YES, explain fully on a separate sheet of paper. Use as many separate sheets as necessary and write your name and Social Security No. on each one.

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**PART I – PERSONAL DATA (continued)**

Please list the names of the persons to whom you have given Part V and VI of this application, your physician, and your two character references.

Physician

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Name of Physician

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Address

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City                      State                      Zip Code

Character References

(1)

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Name

---

Occupation

---

Address

---

City                      State                      Zip Code

(2)

---

Name

---

Occupation

---

Address

---

City                      State                      Zip Code

**PART II – EDUCATION**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Social Security Number

Did you graduate from High School?  Yes  No    Year Graduated \_\_\_\_\_  
Last Year Attended \_\_\_\_\_

Do you have a General Education Development Certificate equivalent to a High School Diploma?  
Yes  No  (If yes attach certificate)

<u>College or University</u>	<u>Location</u>	<u>Dates To - From</u>	<u>Credit Hours</u>	<u>Degree Granted</u>

**Fields of Concentration – As Undergraduate**

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**Fields of Concentration – As Graduate**

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**Other licenses or certificates held and in good standing**

**(Attach Photocopies of All Licenses and professional certificates)**

Name of License	Lic. No.	Licensing Authority	State	Year

**HAVE CERTIFIED TRANSCRIPTS FORWARDED BY COLLEGES DIRECTLY TO THE BOARD OFFICE.**



**PART II – EDUCATION (CONTINUED)**

**List Special Courses in Subjects Relating to Administration/Operation of a Nursing Home  
(Continuing Education Programs. Institutes. Workshops. Etc.)**

Sponsoring Agency & Location

\_\_\_\_\_

Course Title \_\_\_\_\_

Year Attended \_\_\_\_\_ Number of Hours in Session \_\_\_\_\_

Sponsoring Agency & Location

\_\_\_\_\_

Course Title \_\_\_\_\_

Year Attended \_\_\_\_\_ Number of Hours in Session \_\_\_\_\_

Sponsoring Agency & Location

\_\_\_\_\_

Course Title \_\_\_\_\_

Year Attended \_\_\_\_\_ Number of Hours in Session \_\_\_\_\_

Sponsoring Agency & Location

\_\_\_\_\_

Course Title \_\_\_\_\_

Year Attended \_\_\_\_\_ Number of Hours in Session \_\_\_\_\_

Sponsoring Agency & Location

\_\_\_\_\_

Course Title \_\_\_\_\_

Year Attended \_\_\_\_\_ Number of Hours in Session \_\_\_\_\_

Use Additional Sheets If Necessary

List professional Memberships And Activities. Community and Service Group participation. Offices Held and Dates of Office.

Name of  
Organization \_\_\_\_\_

Office Held \_\_\_\_\_  
Date of Office \_\_\_\_\_

Name of  
Organization \_\_\_\_\_

Office Held \_\_\_\_\_  
Date of Office \_\_\_\_\_

Name of  
Organization \_\_\_\_\_

Office Held \_\_\_\_\_  
Date of Office \_\_\_\_\_

Name of  
Organization \_\_\_\_\_

Office Held \_\_\_\_\_  
Date of Office \_\_\_\_\_

Name of  
Organization \_\_\_\_\_

Office Held \_\_\_\_\_  
Date of Office \_\_\_\_\_

**PART III (A) WORK HISTORY**

List your present or most recent job first and work backward to account for all time within the past ten (10) years. Include all time while at work, at school, in military service, unemployed, etc. If your duties and title changed in the course of your service in any one organization indicate such changes clearly and as separate employment periods. Attach extra sheets if necessary to describe additional duties for any one job or for additional jobs.

**Present of Most Recent Job**

Job Title \_\_\_\_\_ Immediate Supervisor \_\_\_\_\_  
Length of Employment – From: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_  
To: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_ Place of Employment \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
State \_\_\_\_\_ Phone No.( ) \_\_\_\_\_ - \_\_\_\_\_  
Duties Performed (if supervisory, indicate extent of Supervision)

**Reason for Job Change:** \_\_\_\_\_

Job Title \_\_\_\_\_ Immediate Supervisor \_\_\_\_\_  
Length of Employment – From: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_  
To: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_ Place of Employment \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
State \_\_\_\_\_ Phone No.( ) \_\_\_\_\_ - \_\_\_\_\_  
Duties Performed (if supervisory, indicate extent of Supervision)

**Reason for Job Change:** \_\_\_\_\_

Job Title \_\_\_\_\_ Immediate Supervisor \_\_\_\_\_  
Length of Employment – From: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_  
To: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_ Place of Employment \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
State \_\_\_\_\_ Phone No.( ) \_\_\_\_\_ - \_\_\_\_\_  
Duties Performed (if supervisory, indicate extent of Supervision)

**Reason for Job Change:** \_\_\_\_\_

**WORK HISTORY CONT.**

Job Title \_\_\_\_\_  
Length of Employment – From: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_  
To: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_  
Duties Performed (if supervisory, indicate extent of Supervision)

Immediate Supervisor \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
State \_\_\_\_\_ Phone No.( ) \_\_\_\_\_ - \_\_\_\_\_

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**Reason for Job Change:** \_\_\_\_\_

Job Title \_\_\_\_\_  
Length of Employment – From: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_  
To: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_  
Duties Performed (if supervisory, indicate extent of Supervision)

Immediate Supervisor \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
State \_\_\_\_\_ Phone No.( ) \_\_\_\_\_ - \_\_\_\_\_

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**Reason for Job Change:** \_\_\_\_\_

Job Title \_\_\_\_\_  
Length of Employment – From: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_  
To: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_  
Duties Performed (if supervisory, indicate extent of Supervision)

Immediate Supervisor \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ Zip Code \_\_\_\_\_  
State \_\_\_\_\_ Phone No.( ) \_\_\_\_\_ - \_\_\_\_\_

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**PART IV - AFFIDAVIT OF APPLICANT**

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STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

I hereby certify that, to the best of my knowledge or belief, there are no misrepresentations or falsifications in the statements and answers I have given in this application. (See last paragraph under NOTES below.)

Further, I certify that the photograph attached below is one of me made within the past three (3) months.

I hereby authorize investigation of all statements contained herein and the references listed to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you.

Applicant's usual signature \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

Signature of Notary \_\_\_\_\_

My commission Expires \_\_\_\_\_ 20\_\_\_\_.

At the right, as indicated, attach a print approximately 2/12x2/12. Enclose a certified check or money order in the amount of Six Hundred Dollars (\$600.00) payable to the West Virginia Nursing Home Administrators Licensing Board. Should investigation by the Board disclose any falsification or misrepresentation, the applicant may be disqualified to take the examination. Falsification of this application can result in denial, suspension, or revocation of the nursing home administrator license.

\_\_\_\_\_  
(Attach Top of Photo at Line)

**APPLICATION FOR RECIPROCAL LICENSE**

**Part V – Medical Certification**

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Name of Applicant	Surname	Given Name	Middle/Maiden Name
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Date

**TO THE PHYSICIAN:**

Please complete this report, which will be held in confidence. Use the REMARKS section below to make any comments pertinent to the suitability of this applicant to practice as a nursing home administrator. Upon completion, please mail this certification to the:

West Virginia Nursing Home Administrators Licensing Board  
P. O. Box 522  
Winfield, WV 25213

I hereby certify that the above named individual who has been my patient for \_\_\_\_\_ years and who was last examined by me on \_\_\_\_\_, (is)\_\_\_(is not)\_\_\_ suitable to be admitted to examination for licensure as a nursing home administrator.

REMARKS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Signature of Physician	Please type or Print Physician's Name
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Physician's Address – Street No. & Name	City	State	Zip Code
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**APPLICATION FOR RECIPROCAL LICENSE**

**Part VI – Certificate of Moral Character**

Full Name of Applicant	Surname	Given Name	Middle/Maiden Name
			Date

Note: This certificate is to be completed by a person who is unrelated to and not in the employment of the applicant.

**TO THE CERTIFIER:**

Use the REMARKS section below for any comments pertinent, in your estimation, to the moral character and suitability of this applicant to practice as a nursing home administrator. Upon completion, please return this certification directly to the:

West Virginia Nursing Home Administrators Licensing Board  
P. O. Box 522  
Winfield, WV 25213

This certifies that I am personally acquainted with the individual named above. I have known h\_\_\_\_ for \_\_\_\_ years and I believe his/her moral character and suitability to be appropriate to the occupation of nursing home administrator. I hereby recommend h\_\_\_\_  
To the West Virginia Nursing Home Administrators Licensing Board.

**REMARKS:**

Signature of Certifier	Occupation of Certifier
Date Signed	Certifier's Address – Street No & Name
	City                      State              Zip Code

**APPLICATION FOR RECIPROCAL LICENSE**

**Part VI – Certificate of Moral Character**

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Full Name of Applicant	Surname	Given Name	Middle/Maiden Name
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Date

Note: This certificate is to be completed by a person who is unrelated to and not in the employment of the applicant.

**TO THE CERTIFIER:**

Use the REMARKS section below for any comments pertinent, in your estimation, to the moral character and suitability of this applicant to practice as a nursing home administrator. Upon completion, please return this certification directly to the:

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This certifies that I am personally acquainted with the individual named above. I have known h\_\_\_\_ for \_\_\_\_ years and I believe his/her moral character and suitability to be appropriate to the occupation of nursing home administrator. I hereby recommend h\_\_\_\_  
To the West Virginia Nursing Home Administrators Licensing Board.

**REMARKS:**

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Signature of Certifier

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Occupation of Certifier

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Date Signed

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Certifier's Address – Street No & Name

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City

State

Zip Code