

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



I. IDENTIFYING INF	ORMATION	(PLEASE	TYPE O	<b>R PRINT</b>	IN INK)						
1. LAST NAME			FIR	IST		MID	DLE				
2. ADDRESS - HOME		STREET	CIT	Y		COUNTY	STATE	ZIP CODE			
ADDRESS - BUSINESS		STREET	CIT	Υ		COUNTY	STATE	ZIP CODE			
3. TELEPHONE NUMBER				4. EMAIL AD	DRESS						
HOME	BUSINESS	CELL									
5. SOCIAL SECURITY NUMB	ER 6.	DATE OF BIRTH		7. PLACE O	F BIRTH	CITY	STATE				
II. RECIPROCITY IN											
1. HAVE YOU EVER A	APPLIED FOR AN A	ADMINISTRATOR LICENSE PLEASE EXPLAIN BELOW		STATE, OF	R ANY OTHE	R STATE?		YES	□ NO		
IF YES, AND LICEN	ISE ISSUED, COM	IPLETE THE FOLLOWING.									
STATE	DATE OF LICENSU	JRE LICENSE NUM	1BER		STA	TUS (CURRENT, EXPIP	ED, ETC.)				
III. OTHER PROFES											
		EVER HELD, A LICENSE F MPLETE THE FOLLOWING		Y OTHER	PROFESSIO	NAL BOARD IN THIS		YES			
STATE T	YPE OF LICENSE	LICENSE NO.	DATE I	SSUED		STATUS	6				
									]		
IF YES, EXPLAIN A	2. HAVE ANY OF YOUR PROFESSIONAL LICENSES LISTED ABOVE EVER BEEN DISCIPLINED?										
IV. CRIMINAL RECO	ORD										
A NURSING HOME 2. HAVE YOU EVER I IS DISHONESTY, F 3. I HEREBY AUTHOR TO CONDUCT A R	OR OTHER HEAL BEEN CHARGED V RAUD OR MORAL RIZE, BY MY SIGN ECORD CHECK OI	VITH, ARRESTED FOR, OF TH CARE FACILITY? IF YE VITH, ARRESTED FOR, OF . TURPITUDE? IF YES, ATT ATURE ON PAGE 4 OF TH N ME, AN APPLICANT FOR IT TO CHAPTER 344., RSI	S, ATTACI CONVIC ACH EXP IS APPLIC LICENSU	H EXPLAN TED OF A LANATION ATION, TH IRE, INCL	NATION. CRIME, AN E J. HE BOARD C UDING THE I	ESSENTIAL ELEMENT ( OF NURSING HOME AD RELEASE OF ANY CLC	CF WHICH	] YES ] YES ORS	□ NO □ NO		
	FOR LICENSURE (	(INCLUDING ARRESTS, CH					LEASE	YES			
HEIGHT											
WEIGHT	-										
				ATTA 0							
COLOR OF HAIR	-				H RECENT	E					
EYES											

### V. EDUCATION RECORD

#### 1. ARE YOU A HIGH SCHOOL GRADUATE, OR HAVE YOU BEEN AWARDED A GED CERTIFICATE? 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
			□ YES □ NO	
			□ YES □ NO	
			□ YES □ NO	
			□ YES □ NO	
			□ YES □ NO	
			□ YES □ 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 ADMINISTRAT	EMPLOYER TELEPHONE NUMBER								
YES NO IF NO, PLEASE EXPLAIN.									
POSITION TITLE(S)		YR.	MO. YR.		NAME AND TITLE OF IMMEDIATE SUPERVISOR				
LIST DUTIES IN EACH POSITION TITLE LISTED ABOVE	E AND IF 1	THE PO	SITION	WAS F	JLL-TIME OR PART-TIME AND NUMBER OF H	HOURS EACH WEEK.			
1.						PART-TIME NUMBER OF HOURS EACH WEE			
2.						PART-TIME NUMBER OF HOURS EACH WEE			
3.						PART-TIME NUMBER OF HOURS EACH WEE			

YES

NO

## BOARD OF NURSING HOME ADMINISTRATORS **APPLICATION FOR LICENSURE - CONTINUED**

POSITION TITLE(S)

2. NAME AND ADDRESS OF EMPLOYER	TYPE OF BUSINESS							
MAY THE MISSOURI BOARD OF NURSING HOME ADMINISTRATO	EMPLOYER TELEPHONE NUMBER							
YES NO IF NO, PLEASE EXPLAIN.								
	FR	OM	Т	O.				
POSITION TITLE(S)	MO. YR. MO.		YR.	NAME AND TITLE OF IMMEDIATE SUPERVISOR				
LIST DUTIES IN EACH POSITION TITLE LISTED ABOVE	AND IF 1	THE PO	SITION	WAS F	ULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.			
1.					FULL-TIME PART-TIME NUMBER OF HOURS EACH WEEK			
2.					FULL-TIME PART-TIME     NUMBER OF HOURS EACH WEEK			
3.					FULL-TIME PART-TIME NUMBER OF HOURS EACH WEEK			
3. NAME AND ADDRESS OF EMPLOYER					TYPE OF BUSINESS			
MAY THE MISSOURI BOARD OF NURSING HOME ADMINISTRATO	RS CON	TACT TH	IS EMPLO	OYER?	EMPLOYER TELEPHONE NUMBER			
POSITION TITLE(S)	NAME AND TITLE OF IMMEDIATE SUPERVISOR							

LIST DUTIES IN EACH POSITION TITLE LISTED ABOVE A	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.						NUMBER OF HOURS EACH WEEK						
2.						NUMBER OF HOURS EACH WEEK						
3.						NUMBER OF HOURS EACH WEEK						
					·							

MO. YR. MO. YR.

4. NAME AND ADDRESS OF EMPLOYER	TYPE OF BUSINESS				
MAY THE MISSOURI BOARD OF NURSING HOME ADMINISTRA	EMPLOYER TELEPHONE NUMBER				
POSITION TITLE(S)	MO.	YR.	MO.	YR.	NAME AND TITLE OF IMMEDIATE SUPERVISOR
LIST DUTIES IN EACH POSITION TITLE LISTED ABOV	E AND IF T	HE PO	SITION	WAS F	ULL-TIME OR PART-TIME AND NUMBER OF HOURS EACH WEEK.
1.					FULL-TIME PART-TIME NUMBER OF HOURS EACH WEEK
2.					FULL-TIME PART-TIME NUMBER OF HOURS EACH WEEK
3.					

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

## BOARD OF NURSING HOME ADMINISTRATORS **APPLICATION FOR LICENSURE** – CONTINUED

APPLICATION	FOR LICENSURE -	<u>- CO</u>	NTIN	JUEL	)						
5. NAME AND ADDRESS OF	EMPLOYER							TYPE OF BUS	SINESS		
	O OF NURSING HOME ADMINISTRATOR	RS CON	TACT THI	IS EMPLO	OYER?			EMPLOYER T	ELEPHONE NUMBER		
		ED	OM	Т	0			-			
POSI	MO.	YR.	MO.	YR.	NAMI	IPERVISOR					
	POSITION TITLE LISTED ABOVE A	ND IF 1	THE PO	SITION	WAS F	ULL-TIME OR PART-TIME	AND NUMBER	OF HOURS EAC			
1.									NUMBER OF HOURS EACH WEEK		
2.									NUMBER OF HOURS EACH WEEK		
						·					
3.									NUMBER OF HOURS EACH WEEK		
VII. GENERAL											
	ITY AFFILIATION (IF ANY, AFFILIATION	MEANS	TO OWN	I, PARTN	ER, OR	ANY FINANCIAL STAKE IN TH	IE OPERATION OF	A FACILITY.)			
NAME OF FACILITY						STREET ADDRESS					
CITY		STATE				COUNTY	ZIP CODE				
BED CAPACITY	LICENSED BY MO. DIVISION OF REG		N AND LI			ADMINISTRATOR	ATOR				
2. YOUR NAME AS YOU WIS	SH IT TO APPEAR ON LICENSE										
3. PLEASE REFER TO THE	INSTRUCTION SHEET POSTED ON TH	IE WEBS	SITE AT V	VWW.HE	ALTH.MO	D.GOV/INFORMATION/BOARD	DS/BHNA WHEN C	OMPLETING THE	APPLICATION.		
ALL CORRESPON	DENCE WILL BE ADDRES	SED	то ус	DUR H	IOME	UNLESS YOU NOT	IFY US DIFF	ERENTLY. Y	OU ARE REQUIRED TO		
	CE OF ANY CHANGE OF H										
73-2.130.											
to the best of my kn	er the penalty of perjury, tha nowledge and belief. I under	rstand									
SIGNATURE	t to Section 344.050, RSMo	).					DATE				
							Di la Contra da				
PLEASE MAIL ALL	DOCUMENTS AND FEE TO	O THE	E FOLI	LOWIN	NG AE	DRESS:	·				
Missouri Departmer Board of Nursing Ho	nt of Health and Senior Servonne Administrators	vices									
Fee Receipts P.O. Box 570											
Jefferson City, MO 6	65102										