



CHECKLIST AND INSTRUCTIONS FOR NURSING HOME ADMINISTRATOR-IN-TRAINING

SUBMIT THE FOLLOWING:

- APPLICATION – This application will not be considered until all sections have been completed. You may need to submit supporting documentation regarding your responses to the licensure questions. Please refer to the application for more information.
- FEE – All fees are non-refundable. The application fee is \$215.00. Make check or money order payable to the Treasurer of Virginia.
- PROOF OF PROFESSIONAL EDUCATION – OFFICIAL transcripts must be received from your school to include school seal, date of graduation, and coursework and/or program completed before licensure will be issued. Proof of Education is not required if you completed an AIT program in Virginia within the past year.
- TRAINING PLAN/DOMAINS OF PRACTICE – Prior to the beginning of the A.I.T. program, the preceptor shall develop and submit for board approval a training plan that shall include and be designed around the specific training needs of the administrator-in-training. An A.I.T. program shall include training in each of the learning areas in the Domains of Practice.
- MODIFIED PROGRAM VERIFICATION OF WORK EXPERIENCE – If requesting a modified program based on work experience, provide third party original documentation of full-time work experience (e.g. letter from employer on company letterhead).

GENERAL INFORMATION ABOUT THE APPLICATION PROCESS

1. It is unlawful to practice as a Nursing Home Administrator-In-Training (AIT) in Virginia until you have been registered by the Board.
2. Applications received without the required processing fee will be returned to the sender.
3. Faxed documents will not be accepted; only original documents will be accepted.
4. Once all documentation has been received, the licensing process takes approximately 10 **business** days. Board staff will contact you at the email address provided on your application with a status update.
5. Applications will remain on file with the board for one year from the date of receipt. If, at the end of one (1) year, licensure/certification/registration is not issued, the applicant shall reapply in accordance with the requirements of the Regulations.



Virginia Department of
Health Professions
Board of Long-Term Care Administrators

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
www.dhp.virginia.gov/nha

(804) 367-4595 (Tel)
(804) 527-4413 (Fax)
Email:
lrc@dhp.virginia.gov

NURSING HOME ADMINISTRATOR-IN-TRAINING APPLICATION

(PLEASE PRINT IN BLUE OR BLACK INK)

FIRST NAME		MIDDLE NAME		LAST NAME AND SUFFIX	
DATE OF BIRTH ____/____/____ MM DD YY		SOCIAL SECURITY NO. OR VA CONTROL NO.*			
ADDRESS OF RECORD**: STREET			CITY	STATE	ZIP CODE
ALTERNATE PUBLIC ADDRESS***: STREET			CITY	STATE	ZIP CODE
HOME PHONE:		WORK PHONE:		MOBILE PHONE:	
PRIVATE E-MAIL ADDRESS			PUBLIC E-MAIL ADDRESS		
GRADUATION DATE ____/____/____ MM DD YY	DEGREE		COLLEGE/UNIVERSITY AND CITY, STATE		

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the process of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. **NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.**

**The address information you provide is your address of record with the Board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be sent to the address of record provided. If you provided a different public address, this information is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.

***This address is subject to public disclosure under the Freedom of Information Act. You may provide an address other than a residence, such as a Post Office Box or a practice location if you wish.

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPROVED BY _____

LICENSE NUMBER	PENDING NUMBER	BASE STATE	RECEIPT NUMBER
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EDUCATION – Please provide an official transcript; No copies or faxes are accepted.

YES NO

1. Have you received a passing grade on a total of 60 semester hours of education from an accredited college or university?

University/College; City; State	Dates Attended	Degree Received	Area of Coursework

MODIFIED PROGRAM REQUEST – You must meet one of the following criteria for a modified program. Please mark the appropriate criteria that applies to you.

YES NO

1. Employed full-time for at least four (4) of the past five (5) consecutive years immediately prior to application as an assistant administrator or director of nursing in a training facility as prescribed in 18 VAC 95-20-330 of the Board’s regulations or as the licensed administrator of an assisted living facility. This requires a 1,000 hour program.

2. Employed full-time for at least three (3) of the past five (5) consecutive years immediately prior to application as a hospital administrator-of-record or an assistant hospital administrator in a hospital setting having responsibilities in all of the following areas: regulatory; fiscal; supervisory; personnel; and management. This requires a 1,000 hour program.

3. Hold a license as a registered nurse and have at least four (4) of the past five (5) years in an administrative level supervisor position in a training facility as prescribed in 18 VAC 95-20-330. This requires a 1,000 hour program.

4. Hold a master’s degree in an unrelated field. This requires a 1,000 hour program.

5. Hold a baccalaureate degree in an unrelated field. This requires a 1,500 hour program

6. Sixty (60) semester hours of education in an accredited college or university. This requires a 2,000 hour program.

7. Hold a master’s or baccalaureate degree in a health care related field that meets the requirements of 18 VAC95-20-221 with no internship. This requires a 320 hour program.

ADMINISTRATOR-IN-TRAINING SUPERVISION

PRECEPTOR FULL NAME		PRECEPTOR LICENSE NUMBER	
PRECEPTOR TELEPHONE NUMBER		PRECEPTOR EMAIL ADDRESS	
FACILITY NAME			
FACILITY ADDRESS	CITY	STATE	ZIP CODE
FACILITY PHONE NUMBER			

Signature of Preceptor

Date

LICENSURE QUESTIONS – To be completed by AIT Applicant

Any supporting documentation related to the questions below should be submitted to:
Virginia Board of Long Term Care Administrators
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233

	YES	NO
1. Have you ever been denied issuance of, refused renewal of a license, or the privilege of taking an examination by any state licensing/regulatory board? If yes, provide notices, orders, etc., from the regulatory authority authorized to take such actions.	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been convicted of a violation of /or pled Nolo Contendere to any federal, state or local statute, regulation, or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? Including convictions for driving under the influence; excluding traffic violations. Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed. Attach your original criminal history record, a certified copy of any final order, decree, or case decision by a court or regulatory agency with lawful authority to issue such order, decree, or case decision, and any other information you wish to be considered with your application (i.e. information on the status of incarceration, parole, or probation, reference letters documentation of rehabilitation, etc.).	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had any of the following disciplinary actions taken against any license to practice a health profession or any such actions pending? For example: (a) suspension/revocation (b) probation (c) reprimand/cease and desist (d) had your practice monitored (e) monetary penalty? If yes, submit notices, orders, etc., from the regulatory authority authorized to take such actions.	<input type="checkbox"/>	<input type="checkbox"/>

MILITARY SERVICE**YES NO**

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1. Are you active-duty military?
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2. Are you relocating to Virginia or an adjoining state or the District of Columbia with a spouse who is 1) on federal active duty orders, or 2) a veteran who has left active duty service within one year of submission of this application?
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ADDITIONAL LICENSURE QUESTIONS**YES NO**

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- A. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner?
Please provide a full explanation on a separate page.
(A.2) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior?
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- B. Within the past five years, have you been disciplined by any entity?
Please provide a full explanation and any associated orders or letters from the entity.
(B.2) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior?
-
- C. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing administrator or trainee.

If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)
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- D. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing administrator or trainee.

If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)
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- E. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing administrator or trainee.

If yes, please provide a full explanation. (NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)
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F. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity?

If yes, please provide a full explanation and any associated orders or letters from the entity.

(NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.)

AFFIDAVIT OF APPLICANT

I certify that I have carefully read the laws and regulations related to the practice of Nursing Home Administrators, which are available at https://www.dhp.virginia.gov/nha/nha_laws_regs.htm and I fully understand that funds submitted as part of the application process shall not be refunded.

I certify by my signature below: I am the person applying for licensure/certification/registration and meet the qualifications required by Virginia law and regulations. Further, I certify the information provided on this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information required in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

I agree to the above certification.

Signature of Applicant

Date