



CHECKLIST AND INSTRUCTIONS FOR **PRECEPTOR REINSTATEMENT APPLICATION**

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. Make check or money order payable to the Treasurer of Virginia.
The fee for application for Reinstatement is \$105.00 (if registration has been expired for one year or more)
The fee for application for Reinstatement After Disciplinary Action (Suspension, Revocation, or Denial of Renewal) is \$1,000.00
- NATIONAL PRACTITIONER DATA BANK (NPDB)** – You will need to request a current self-query report from the NPDB. There are processing fees for each entity for this service. You may request the report through their website at www.npdb.hrsa.gov. You must submit your completed NPDB report to the Board by fax, email, or mail.
- VERIFICATION OF LICENSURE** – You must provide written verification directly from the issuing regulatory authority, in all United States, its territories, the District of Columbia, or Canadian jurisdictions, in which you have ever held a license, including expired, inactive, and current licenses.
- VERIFICATION OF WORK EXPERIENCE** – Provide written verification of full-time employment as an administrator in a training facility or facilities for a minimum of two of the past four years immediately prior to registration or be a regional administrator with on-site supervisory responsibility for a training facility or facilities. Provide original third party documentation of work experience from employer on company letterhead mailed to the board by your employer that include dates of employment, location of work experience, and specific duties assigned. A resume may not be used as a substitute for proof of employment.
- PRECEPTOR TRAINING COURSE COMPLETION** – Provide evidence that you have completed the [online preceptor training course](#) for all training modules offered by the National Association of Long Term Care Administrator Boards.

GENERAL INFORMATION ABOUT THE APPLICATION PROCESS

1. It is unlawful to practice as an Assisted Living Facility (ALF) or Nursing Home Administrator (NHA) Preceptor in Virginia until you have been issued a Virginia registration.
2. Applications received without the required processing fee will be returned to the sender.
3. Documentation may be submitted electronically to lrc@dhp.virginia.gov; however, certain information must be submitted from the primary source for items such as verifications of licensure from other jurisdictions and work experience from employers. Documentation related to affirmative answers to the licensure questions must be submitted to the Board in their original format by mail if requested by the Board.
4. Once all documentation has been received, the registration process can take up to 30 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) 939-5973 (Fax)
Email:
lrc@dhp.virginia.gov

PRECEPTOR REINSTATEMENT APPLICATION

MARK ONLY ONE BOX:	MARK ONLY ONE BOX:
<input type="checkbox"/> Assisted Living Facility Administrator (ALFA) Preceptor	<input type="checkbox"/> Reinstatement
License Number:	<input type="checkbox"/> Reinstatement after Suspension
<input type="checkbox"/> Nursing Home Administrator (NHA) Preceptor	<input type="checkbox"/> Reinstatement after Revocation
License Number:	<input type="checkbox"/> Reinstatement after Denial of Renewal

(PLEASE PRINT IN BLUE OR BLACK INK)

FIRST NAME	MIDDLE NAME	LAST NAME
SOCIAL SECURITY NUMBER OR VIRGINIA DMV CONTROL NUMBER*		
DATE OF BIRTH (mm/dd/yyyy)	MAIDEN/OTHER NAME(S), IF APPLICABLE	

*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.**

ADDRESS OF RECORD INFORMATION

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.

ADDRESS STREET	CITY	STATE	ZIP CODE
PHONE NUMBER	OTHER PHONE NUMBER		
E-MAIL ADDRESS			

PUBLISHED INFORMATION

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.

ADDRESS STREET	CITY	STATE	ZIP CODE
PHONE NUMBER	E-MAIL ADDRESS		

OUT OF STATE LICENSURE: List all United States, its territories, the District of Columbia, or Canadian jurisdictions in which you have been issued a physical therapy, including active, inactive, or expired licenses. You may use additional paper if needed.

STATE/JURISDICTION	LICENSE NUMBER	ISSUE DATE / STATUS

REINSTATEMENT QUALIFICATIONS

YES NO

1. Have you been employed full-time as an administrator in a training facility or facilities for a minimum of two (2) of the past four (4) years immediately prior to registration, or been a regional administrator with on-site supervisory responsibilities for a training facility or facilities?

WORK HISTORY – A resume may not be used as a substitute for any question on this application. You may use additional paper if needed.

From	To	Employer (Name, Address, City, State, Zip Code)	Position Title

LICENSURE QUESTIONS

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.

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.).

	YES	NO
3. Have you ever had any of the following disciplinary actions taken against your license to practice as an administrator or to practice any 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?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, submit notices, orders, etc., from the regulatory authority authorized to take such actions.

MILITARY SERVICE	YES	NO
1. Are you active-duty military?	<input type="checkbox"/>	<input type="checkbox"/>
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, <u>or</u> 2) a veteran who has left active duty service within one year of submission of this application?	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL LICENSURE QUESTIONS	YES	NO
A. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? If yes, please provide a full explanation. Note: The Board may ask for additional documentation.	<input type="checkbox"/>	<input type="checkbox"/>
B. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? If no, please provide a full explanation. Note: The Board may ask for additional documentation.	<input type="checkbox"/>	<input type="checkbox"/>
C. 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?	<input type="checkbox"/>	<input type="checkbox"/>
Please provide a full explanation on a separate page.		
D. Within the past five years, have you been disciplined by any entity?	<input type="checkbox"/>	<input type="checkbox"/>
Please provide a full explanation and any associated orders or letters from the entity.		
E. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity?	<input type="checkbox"/>	<input type="checkbox"/>
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 Assisted Living Facility Administrators or Nursing Home Administrators, which are available at <https://www.dhp.virginia.gov/Boards/LTCA/> 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