ADMINISTRATOR LICENSURE/CERTIFICATION VERIFICATION FORM

This form must be sent and completed by the state(s) in which you currently have an Assisted Living or Nursing Home Administrators’ license or certification. The form must be returned to the address or fax number listed above by the state official who completed the form.

Administrator Name: ___________________________ License/Certification #: ______________

Administrator Type:  ☐ Assisted Living Facility ☐ Nursing Home

Issue Date: _______________  State: _______________  Expiration Date: _______________

Did the individual complete an administrator training program for licensure/certification?

☐ Yes  ☐ No

If yes, how long was the administrator training program? ________________________________

Has the individual ever received a refusal, suspension, or revocation of their administrator license/certification?

☐ Yes  ☐ No

Has the individual ever received any complaints or pertaining to their administrator license/certification?

☐ Yes  ☐ No

Does the individual have any pending investigations against their administrator license/certification?

☐ Yes  ☐ No

Individual completing form: ___________________________  Title: _________________________

Date: ___________________________  Phone Number: ________________________________