Application for Nursing Home Administrators by Examination

Board of Nursing Home Administrators
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasnursinghomeadmin.gov
Email: info@floridasnursinghomeadmin.gov
Phone: (850) 245-4355
FAX: (850) 922-8876

Florida HEALTH
Medical Quality Assurance

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

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Do Not Write in this Space
For Revenue Receipting Only

Examination (1010) **$755.00**

Total fee of $755.00 includes the following:

Application Fee	$250.00
Initial Licensure Fee	$500.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $505.00 (Initial Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Certain fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

_____ _____ _____
Street Apt. No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with Section 60-3, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), F.S., authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Section 653 and 654; and Sections 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice as a Nursing Home Administrators or any other health-related license(s)? ☐ Yes ☐ No

C. List all health-related licenses (active, inactive or lapsed).

License Type	License #	State/Country	Original Date Issued	Expiration Date	Status of License

☐ **Submit a License Verification** form to **ALL** your state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

D. List in chronological order from the date of graduation to present date, all practice employment, non-employment and/or any unaccounted period. (Attach additional sheets if necessary.)

Name of Business	Full Mailing Address	Employment Dates (From- To) MM/DD/YYYY

E. Have you ever had an application for a professional license, or any application to practice, denied by any state board or governmental agency (state or country)? ☐ Yes ☐ No

F. Have you ever been notified/required to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Nursing Home Administrators Practice Act, unprofessional, or unethical conduct? ☐ Yes ☐ No

If you responded "Yes" to question E or F, complete the following:

Name of Agency	State	Action Date: MM/DD/YYYY	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

Name: _____

5. EDUCATION & TRAINING HISTORY

A. List undergraduate, graduate, and professional education, listing all schools/colleges/universities attended, whether completed or not, in chronological order.

School Name	City/State or Country	Dates of Attendance (From-To) MM/DD/YYYY	Graduation Date	Degree Awarded

☐ **All applicants must have an official transcript forwarded directly to the board office from your educational program. Diplomas and student copies are not acceptable. Transcripts should be sent to:**

Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

B. List in chronological order from date of graduation/completion of all professional/postgraduate training (Internship/Residency/Fellowship):

Program Name	City/State	Dates of Attendance (From- To) MM/DD/YYYY	Completion Date

C. Did you successfully pass a national certification examination in the area you are applying for?
☐ Yes ☐ No

If you responded "Yes," provide the following:

Name of National Certification Exam	Exam Date

☐ **The verified certification must be mailed directly from the national certifying body to the board at:**

Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Name: _____

6. EXAMINATION INFORMATION

The Florida Nursing Home Administrators Examination consists of **two parts**: the **NHA examination** and the **Florida Laws and Rules examination**. The NHA examination is developed and administered by the National Association of Board of Examiners of Nursing Home Administrators (NAB). Upon board approval, you must submit your application through NAB's CDOM system on their website at www.nabweb.org to be scheduled to take the examination. The NAB CDOM will email a response providing you with your eligibility, your authorization to test letter, the toll-free number for use in scheduling your examination, and a list of testing centers with appropriate online scheduling instructions.

The **Florida Laws and Rules examination** is developed by the Florida Department of Health and administered by the contracted vendor. Both exams are given on a continued basis. For any information on examination scheduling please contact NAB at (202) 712-9040.

Eligibility for National Examination:

a. **One Year Practical Experience:** If you are applying based on a degree and one year of management experience in the areas of executive duties and skills, including staffing, budgeting, and directing resident care, dietary and bookkeeping departments within a skilled nursing facility, hospital, hospice, assisted living facility with a minimum of 60 licensed beds, or geriatric residence treatment program and, if such experience is not a skilled nursing facility, has fulfilled the requirements of a 1,000 hour nursing home administrator-in-training program prescribed by the board. The proof of experience must include a statement from your employer stating the beginning and ending dates that you held in the position, named facilities, job descriptions and organization charts.

b. **Internship/A.I.T. Training:** Verification must include a statement directly from the college/university program director certifying successful completion of all internship training and verification of the number of clock hours, for each nursing home. The applicant must submit the **"Certificate of Internship/A.I.T. Training Preceptor's Statement"** form.

Review and Study Courses:

The following organization offers a review or study course for the Nursing Home Administrators examination (NAB). The Board of Nursing Home Administrators is not recommending this course, but is advising that it is available. To receive additional information on dates and times the review is given, please contact the provider directly:

Professional Health Care Education Systems, Inc.
P.O. Box 291883
Tampa, FL 33617
Attn: Inez Joseph, Ph.D.
Phone: (813) 982-1554

Name: _____

This information is exempt from public records disclosure.

7. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation,** identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

8. **DISCIPLINE HISTORY**

A. Have you ever had a license disciplined for sexual misconduct or committed any act in any other state that would constitute sexual misconduct? ☐ Yes ☐ No

B. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action in any state or other jurisdiction? ☐ Yes ☐ No

C. Have you ever been refused a license to practice, or the renewal thereof in any state? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date: MM/DD/YYYY	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

9. **CRIMINAL HISTORY**

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. ☐ Yes ☐ No

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date: MM/DD/YYYY	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

10. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in Section 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under Section 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes" please provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

Name: _____

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the following questions, please provide:

☐ **A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address listed on the first page of the application.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documents in sections 7, 8, 9, and 10 must be mailed to:

Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

11. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 456.072, 468.1745 and 468.1755, F.S.

I understand that Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed. Failure to do so may result in action by the board including denial of licensure.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
MM/DD/YYYY

Complete verifications must be mailed directly from the licensing agency to:

Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Board *of* Nursing Home Administrators License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Nursing Home Administrators.

Applicant's Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

- Typed on an official state form or letterhead
- Include an official board seal
- Signature and title of state board official

The following information must be included in all verifications:

- Licensee name
- License number
- State or jurisdiction of licensure
- Licensure status
- Is license in good standing?
- Date of issuance/expiration
- Title of License
- Licensure method (examination, grandfathering, reciprocity/endorsement)
- Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
- If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.
- If the applicant took a written examination: what exam was it (NAB, PES, Other)? Exam dates, Exam Series #, Total Raw Score

Complete verifications must be mailed directly from your preceptor to:

Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Board *of* Nursing Home Administrators
Certificate of Internship/A.I.T. Training Preceptor's Statement

Part I: To be completed by applicant /trainee

Applicant/Trainee Name: _____

Part II: To be completed by your Preceptor

Administrators Name: _____ License #: _____

Name of Nursing Home: _____

Address: _____
Street and Number Apt # City State ZIP

Please select: ☐ Internship ☐ A.I.T.

Dates: _____ to _____ Weeks/Hours: _____
MM/DD/YYYY MM/DD/YYYY

During this training period, the administrator in training has not performed in a dual capacity and was singularly involved in the Internship/A.I.T. Program.

Internship: _____
Name of Approved College or University

A.I.T.: _____
Names of Florida Board Monitor

List actual percent of total hours listed above: (Total will equal 100%) Actual

1. **Resident Care:** Nursing; Food; Social & Recreational Services; Volunteers; Pharmacy Rehabilitation; Physicians' Services and Medical Records *(should be 20% minimum)* _____
2. **Personnel:** Recruitment; Interviews, Employee Selection; Training; Personnel Policies; Health and Safety *(should be 15% minimum)* _____
3. **Finance:** Accounting; Budgeting; Financial Planning & Asset Management *(should be 15% minimum)* _____
4. **Marketing:** Public Relations Activities & Marketing Programs *(should be 5% minimum)* _____
5. **Physical Resource Management:** Safety Procedures; Fire & Disaster Planning; Building And Environment Maintenance *(should be 10% minimum)*
6. **Laws, Regulatory Code and Governing Boards:** Federal, State and Local laws; Rules and Regulations *(should be 10% minimum)* _____

Evaluation of Internship/A.I.T.: ☐ Superior ☐ Satisfactory ☐ Unsatisfactory

_____ _____
Signature of Preceptor Date (MM/DD/YYYY)

Complete verifications must be mailed directly from your preceptor to:

Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Board *of* Nursing Home Administrators
Eligibility for Examination – Administrator-in-Training
(Section 468.1695(2)(b)2, F.S.)

Part I: To be completed by applicant

Name: _____

Address: _____

Telephone Number: _____

(An official transcript must be sent directly from the education institution to this office.)

Part II: To be completed by your Preceptor

☐ Baccalaureate in Health Care Administration

☐ Baccalaureate in Health Services Administration ☐ Baccalaureate (other)

Degree Title: _____

Name of College/University: _____

Address: _____
Street and Number Apt # City State ZIP

Date of Graduation: _____ Accredited by: _____

Administrator in Training: board approved as prescribed by Chapter 64B10-16, F.A.C.

Select: ☐ 1,000 hours ☐ 2,000 hours

Preceptor Name: _____ Number of Hours: _____

Name of Nursing Home: _____

Address: _____
Street and Number Apt # City State ZIP

Board Monitor's Name: _____ License Number: _____

Date Completed: _____ Number of Beds: _____
MM/DD/YYYY

Preceptor's Signature: _____ Date: _____
MM/DD/YYYY

Complete verifications must be mailed directly from your preceptor to:

Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Board *of* Nursing Home Administrators
Eligibility for Examination - Internship
(Section 468.1695(2)(a)2, F.S.)

Part I: To be completed by applicant

Name: _____

Address: _____

Telephone Number: _____

(An official transcript must be sent directly from the educational institution to this office.)

Part II: To be completed by your Preceptor

☐ Baccalaureate in Health Care Administration

☐ Baccalaureate in Health Services Administration ☐ Baccalaureate (other)

Degree Title: _____

Name of College/University: _____

Address: _____
Street and Number Apt # City State ZIP

Date of Graduation: _____ Accredited by: _____

Internship Program: If more than one nursing home was needed for completion of program, attach additional page(s) with the information provided below for each nursing home. Attach verification from preceptor documenting completion of Internship/A.I.T. Program and statement from the college/university as to the number of credit hours for the internship program.

Name of College/University: _____

Address: _____
Street and Number Apt # City State ZIP

Number of Hours: _____ Date of Completion: _____

Name of Nursing Home: _____ Number of Beds: _____

Address: _____
Street and Number Apt # City State ZIP

Preceptor's Name: _____ License Number: _____

Preceptor's Signature: _____ Date: _____
MM/DD/YYYY

Complete verifications must be mailed directly from your supervisor to:

Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Board *of* Nursing Home Administrators
Eligibility for Examination – One Year Practical Experience
(Section 468.1695(2)(b)2. b, F.S.)

Part I: To be completed by applicant

Name: _____

Address: _____

Telephone Number: _____

(An official transcript must be sent directly from the educational institution to this office.)

Part II: To be completed by your Supervisor

☐ Baccalaureate in Health Care Administration

☐ Baccalaureate in Health Services Administration ☐ Baccalaureate (other)

Degree Title: _____

Name of College/University: _____

Address: _____
Street and Number Apt # City State ZIP

Date of Graduation: _____ Accredited by: _____

☐ **One Year Management Experience:** Provide organization chart, job description, and statement from employer verifying your responsibilities and experience with specific dates to document one year of experience.

Skilled Nursing Facility (SNF): _____

Title of Position: _____

Name of Nursing Home: _____ Number of Beds: _____

Address: _____
Street and Number Apt # City State ZIP

Telephone Number: _____ Dates: _____ to _____
MM/DD/YYYY MM/DD/YYYY

Supervisor's Name: _____ Title: _____

Supervisor's Signature: _____ Date: _____
MM/DD/YYYY

Candidate Request for Special Examination Accommodations

If you have a disability covered by the Americans with Disabilities Act, submit to Professional Examination Service, this completed form and attach supporting documentation of your disability and need for accommodators so your accommodations for testing can be processed efficiently. The information you provide and any documentation regarding your disability and your need for accommodations in testing will be treated with strict confidentiality.

Applicant Information:

Name: _____
Last/Surname First Middle

Address:

_____
Line 1

_____
Line 2

_____
City State ZIP

_____
Jurisdiction in which you have applied for licensure

Special Accommodations- I request special accommodations for the administration of the (check each examination that applies to you):

☐ Nursing Home Administrators Licensing Exam (NHA)

☐ State-Based Laws & Regulations Exam (NSBL)

Please provide (check all that apply):

☐ Accessible testing site

☐ Special Seating

☐ Large print test (specify font size) _____

☐ Reader

☐ Circle answers in test booklet

☐ Extended testing time (time and a half)

☐ Separate testing area

☐ Other special accommodations (specify) _____

_____

Send original documentation to:
PSI Services, LLC
3210 E. Tropicana
Las Vegas, NV 89121

Send copies to:
Board *of* Nursing Home Administrators
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257