State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

Health Facility Administrator

APPLICANT INFORMATION

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

Please Select ONE:

- ☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- ☐ I am a foreign national not physically present in the United States.
- ☐ None of the above, please explain: _____

Driver License or State ID Card _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Applicant: _____ Date _____

QUALIFYING QUESTIONNAIRE

Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

1.	☐ Yes ☐ No	Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?
2.	☐ Yes ☐ No	Do you CURRENTLY have **any criminal action active or pending**?
3.	☐ Yes ☐ No	WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance,** or been **convicted** of **a misdemeanor** in any jurisdiction?
4.	☐ Yes ☐ No	Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **felony** in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2,3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You **do not need to report** Juvenile Court adjudications; however, you do need to report convictions as a minor tried outside of Juvenile Court.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

PROFESSIONAL LICENSES

List all other licenses, registrations or certifications issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

Profession: _____ **License Number:** _____

Issuing State: _____ **License Status:** _____ **Issue Date:** _____

If you identified a health facility administrator license above, please answer the following:

☐ Yes ☐ No After obtaining the license(s) above, have you engaged in at least one year of experience in the state, district, or territory of the United States where the license was issued?

Note: If you answer yes to the question above, please see the checklist at the end of this application or our website for instructions on applying for licensure by endorsement.

MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

☐ Yes ☐ No a hospital or health care facility

☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program

☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency

☐ Yes ☐ No malpractice insurance coverage

☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

☐ Yes ☐ No a hospital or health care facility

☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program

☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency

☐ Yes ☐ No malpractice insurance coverage

☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:

☐ Yes ☐ No a hospital or health care facility

☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program

☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency

☐ Yes ☐ No malpractice insurance coverage

☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http://www.npdb.hrsa.gov.*

If you answered **"Yes"** to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

Affidavit of Completion of AIT Preceptorship

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

EMPLOYMENT INFORMATION

To be completed by the Preceptor.

Name of Preceptor: _____ **License Number:** _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number: _____ **Email:** _____

Dates of Employment/Supervision: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

Total Hours Supervised Practice: _____

Is the applicant currently employed with the facility? ☐ Yes ☐ No

If no, is the applicant re-hirable? ☐ Yes ☐ No, Please explain: _____

_____

I certify that I am a licensed health facility administrator in good standing and have been the preceptor for the AIT applicant named above. I have personally supervised the AIT training program for the applicant for licensure as a health facility administrator. I further certify that this supervision was on a personal basis and that the AIT under my supervision fulfilled the AIT preceptorship as outlined in Utah Administrative Rule R156-15-307.

Signature of Supervisor: _____ **Date:** _____

Verification of Health Facility Administrator Experience

Each supervisor must complete a separate form. The hours of all forms must total 8,000.

APPLICANT INFORMATION

To be completed by the applicant.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

EMPLOYMENT INFORMATION

To be completed by the Supervisor.

Name of Establishment: _____

Name of Supervisor: _____ **License Number:** _____

Establishment Address: _____
Street/PO Box *City* *State/Zip*

Telephone Number: _____ **Email:** _____

Dates of Employment/Supervision: _____ to _____
MM/DD/YYYY *MM/DD/YYYY*

How many hours per week did the applicant work? _____ ☐ Part time ☐ Full Time

Total Hours Supervised Practice: _____

Total Hours Managerial Experience: _____

Is the applicant currently employed with the facility? ☐ Yes ☐ No

If no, is the applicant re-hirable? ☐ Yes ☐ No, Please explain: _____

I do hereby certify that the applicant for licensure as health facility administrator has successfully completed the above hours of supervised experience as a W-2 employee of the facility listed. I certify that the experience supervised meets the requirements outlined in R156-15-307.

I further certify that the applicant is qualified and competent to practice as a licensed health facility administrator.

Signature of Supervisor: _____ **Date:** _____

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience; you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

ALL APPLICANTS

The following items are required to complete your application:

- ☐ $120.00 non-refundable application-processing fee, made payable to "DOPL".
- ☐ Supporting documentation for any "yes" answers provided on the either of the qualifying questionnaires.

LICENSURE BY APPLICATION

If applying for **licensure by application**, *in addition* to the items required for all applicants, you must submit the following items:

- ☐ Official verification of passing the National Association of Boards of Examiners for Nursing Home Administrators (NAB) Examination with a minimum score of 113. ***NOTE:*** If you have not yet taken and passed the NAB Exam and do not qualify for temporary license (see below), do not turn in this application. You must submit the "Request for Authorization to Test: HFA" application.
- ☐ Affidavit of Completion of AIT Preceptorship.
- ☐ Documentation of meeting one of the following education and experience options:
  - Official transcripts documenting a minimum of a Bachelor's degree from an accredited school that may include 500 hours in an internship, practicum or outside study program in health care or facility administration. ***NOTE:*** Transcripts are considered "official" when they are sent directly from the school to DOPL or sealed in an envelope bearing the school's stamp/seal on the envelope flap.
  OR
  - Original "Verification of Health Facility Administrator Experience" form found in this application documenting a minimum of 8,000 hours experience (at least 4,000 shall be in a supervisory role) and W2, K1, or other documents for the years indicated on the form.

**NOTE:* *If you previously submitted these documents with your "Request for Authorization to Test", you do not need to submit them again.*

TEMPORARY LICENSURE DUE TO UNEXPECTED CIRCUMSTANCES

A temporary license may be issued without examination to a person who meets all other requirements established by statute and by rule to fill an *immediate, unexpected* vacancy. It is the applicant's responsibility to prove the vacancy was unexpected. The temporary license is valid for a single six-month period, and cannot be extended. To request a temporary license under these limited circumstances, you must contact the Division directly.

LICENSURE BY ENDORSEMENT

If applying **licensure by endorsement**, *in addition* to the items required for all applicants, you must submit the following items:

- ☐ Official verification, showing active licensure in good standing for at least one year, from a jurisdiction designated by the Division as equivalent to Utah. Please see our website for additional information regarding approved states.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Occupational and Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Occupational and Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741