UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Health Facility Administrator

Clear Form

APPLICANT INFORMATION

Full Legal Name: _____ _____ _____
First Middle Last

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN:* _____ Date of Birth: _____ Gender: ☐ Male ☐ Female
* If you don't have a social security number, please follow the instructions on the last page.

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

City: _____ State: _____ Zip: _____

Phone: (____) _____– _____ Email: _____
Note: All Division notices and communication will be sent to this 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

I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, and 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.

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 Department of Commerce, State of Utah, any files, records, or information of any type reasonably required for the Department to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

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.

I understand that I am responsible to update the Department of any changes relating to my application/license/certification/registration.

I understand that if the application is not complete at the time of submission, it will delay approval and could result in a denial.

I declare under criminal penalty under the law of Utah that this application is true and correct.

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.

Please **DISCLOSE** the following:

- charges that were later held in abeyance (plea in abeyance), diverted, reduced, or dismissed.
- motor vehicle offenses such as driving while impaired or intoxicated.
- 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:

- minor traffic offenses such as parking or speeding violations.
- juvenile offenses, unless you were tried as an adult.
- legally expunged or sealed criminal history incidents.

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

PROFESSIONAL LICENSES

List all other licenses, registrations or certification 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 (or equivalent) 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 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.

NATIONAL PROVIDER IDENTIFIER (NPI)

Your NPI: _____

UTAH DEPARTMENT OF COMMERCE
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Affidavit of Completion of Administrator in Training (AIT) Preceptorship

APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

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

Address: _____ City: _____ State: _____ Zip: _____

EMPLOYMENT INFORMATION: (TO BE COMPLETED BY THE PRECEPTOR)

Preceptor Name: _____ _____ _____ License Number: _____
First *Middle* *Last*

Phone: (_____) _____ – _____ Email: _____

Name of Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Dates of Employment/Supervision: _____ to _____

Total Hours Supervised Practice? _____

Is the applicant still employed with this facility? ☐ Yes ☐ No

If no, is the applicant re-hirable? ☐ Yes ☐ No

If not re-hirable, please explain: (attach additional form if needed)

ATTESTATION: ☐ ☐

I certify that I am a licensed Health Facility Administrator in good standing. I have personally supervised the AIT training program for the applicant listed above, 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 Admin. Rule R156-15-307.

I declare under criminal penalty under the law of Utah that this information is true and correct.

Signature of Preceptor: _____ Date: _____

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Verification of Health Facility Administrator Experience

Health Facility Administrator applicants applying for licensure based on experience rather than formal education, must submit this form, or multiple copies of this form, documenting a total of 8,000 hours experience (including a minimum of 4,000 hours in supervisory roles) and W2, K1, or other documents supporting the experience attested to on this form.

Each supervisor must complete a separate form.

APPLICANT INFORMATION (TO BE COMPLETED BY THE APPLICANT)

Full Legal Name: _____ (First) _____ (Middle) _____ (Last)

Address: _____ City: _____ State: _____ Zip: _____

EMPLOYMENT INFORMATION: (TO BE COMPLETED BY THE SUPERVISOR OR SELF-EMPLOYED PRACTITIONER)

Supervisor Name: _____ (First) _____ (Middle) _____ (Last) License Number: _____

Phone: (_____) _____ – _____ Email: _____

Name of Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Dates of Employment: _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

How many hours did the applicant work per week? _____

The applicant worked: ☐ Full time ☐ Part time.

Total Hours Supervised: _____ Total Hours Managerial Experience: _____

Is the applicant still employed? ☐ Yes ☐ No

If no, is the applicant re-hirable? ☐ Yes ☐ No

If not re-hirable, please explain: (attach additional form if needed)

ATTESTATION:

I do hereby certify that the applicant for licensure as Health Facility Administrator has successfully completed the above hours of supervised experience as an 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.

I declare under criminal penalty under the law of Utah that this information is true and correct.

Signature of Supervisor: _____ Date: _____

Supervisor's Title: _____

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.

If you do not have a valid Social Security number, you must submit your Individual Taxpayer Identification Number (ITIN), Alien Registration Number (A-number), or a copy of an unexpired government issued passport from your country of residence and an intent-to-hire letter from a Utah based employer (Utah Code § R156-1-301). Submission of the above documents may require additional documents to demonstrate lawful presence (Utah Code § 63G-12-402 (3)(k)).

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.

- ☐ Documentation of meeting one of the following education and experience options:
  - Affidavit of Completion of AIT Preceptorship.

  OR
  - Submit documentation of NAB Health Services Executive (HSE) credential.
  - 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.*

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.

TEMPORARY LICENSURE Due to Unexpected Circumstances

A temporary license may be issued to a person who meets all other requirements established by statute and rule to fill an *immediate, unexpected* vacancy. 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.

Submit completed application to the Division:

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

By in-person or express delivery:
Division of Professional Licensing
Heber M Wells Building, 1st Floor
160 E 300 S
Salt Lake City, UT 84111

If you have questions, please contact the Division at 801-530-6628 or by email at B2@Utah.gov.