



COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF HEALTH PROFESSIONS LICENSURE  
**BOARD OF REGISTRATION OF NURSING HOME ADMINISTRATORS**  
239 CAUSEWAY STREET, SUITE 500  
BOSTON, MA 02114  
800-414-0168  
617-973-0806

[www.mass.gov/dph/boards/nh](http://www.mass.gov/dph/boards/nh)

**INSTRUCTIONS FOR RECIPROCITY APPLICATION  
NURSING HOME ADMINISTRATOR**

**General Information About the Application Process:**

To facilitate the processing of your application, please ensure that you provide all the information requested. **DO NOT LEAVE BLANKS.** If you are unable to provide the requested information, attach a separate sheet with an explanation. Missing information will delay the processing of your application.

As an applicant, it is your responsibility to ensure that ALL supporting documentation for licensure is sent directly to the Board and to check with the Board on the status of your application.

All requested information must be provided; failure to provide requested information may result in a delay in processing of application. **Incomplete applications will be returned to applicant.**

**Completed Applications must include the following:**

1. **The following documents must be submitted at the same time in one envelope:**
  - a. Completed application form, signed by the applicant and notarized.
  - b. 2 x 2 passport style color photo (white or off-white background); copies and printer generated photos are not acceptable.
  - c. Signed and notarized Criminal Offender Record Information (CORI) Acknowledgement Form obtained from the Board's website.
  - d. Check or money order payable to the Commonwealth of Massachusetts for \$225.00; cash or foreign currency is not accepted.
  - e. Three professional references. **Note:** may not be relatives, spouses, family members or subordinates.
  - f. One personal reference. **Note:** may not be a spouse, partner, family member or subordinate.
  - g. Completed physician form.

**NOTE:** Provide a self-addressed envelope to your endorsers with your Reference Forms and Physician Form. After the individual has completed the form, he/she must seal it in the return envelope you provide, sign his/her name across the envelope seal, and return it to you.

2. Official transcripts in signed, sealed envelopes for all undergraduate degrees and any other post-secondary degrees. When requesting official transcripts, please inform each school's registrar that the **transcript must be complete and indicate the degree and date conferred in mm/dd/yyyy format.** Transcripts may be sent directly to the Board by the institutions.

3. A current resume or curriculum vitae that describes your long term facility experience and includes the name and complete address of all employers, dates of employment, position titles and duties.
4. Copy of a current valid Nursing Home Administrator license from the state in which you are practicing. The copy must provide the license number and expiration date.
5. State Verification Form from the state you are currently practicing as a nursing home administrator in a signed, sealed envelope. Verification must be sent directly to the Board by the other state or jurisdictions you are currently practicing;
6. Verification of licensure status, in signed, sealed envelopes, from any state or jurisdiction in which you now hold or have previously held any professional license. Verification must be sent directly to the Board by other states or jurisdictions;
7. The **Original** report from the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self-Query. To request a Self-Query, please contact the National Practitioner Data Bank at 1-800-767-6732 or at <http://www.npdb.hrsa.gov/>. Keep a copy for your records.
8. NAB credentialing exam score in a signed, sealed envelope from the Interstate Reporting Service. To request a score, please contact the Interstate Reporting Service at 475 Riverside Drive New York, NY 10115, telephone number (212) 367-4293, or [www.proexam.org](http://www.proexam.org).
9. Documentation of compliance with the Board's continuing education requirements at the time of application for the current continuing education cycle.

**NOTE A:** The Board requires a minimum of forty (40) contact hours of continuing education between July 1<sup>st</sup> of each even-numbered calendar year and June 30 of the next even-numbered calendar year.

**NOTE B:** If you have been licensed as a nursing home administrator for less than 19 months you are exempt from this continuing education requirement. Submit a written statement requesting the exemption.

**NOTE C:** The Board accepts certificates of attendance that clearly state the licensee's name, date(s) of the program, title of program, number of contact hours of continuing education awarded and information that documents that the program has been approved by NAB or the Board.

10. **American College of Healthcare Administrators Members:** If an applicant for reciprocity holds a current valid license as a nursing home administrator in another state and also holds current certification as a nursing home administrator from the American College of Healthcare Administrators the following documents may be submitted in lieu of the materials listed in #3-9:
  - a. Copy of a current valid Nursing Home Administrators license from the state in which you are practicing. The copy must provide the license number and expiration date.
  - b. Verification from the state you are currently practicing in that your license is in good standing in a signed, sealed envelope.
  - c. Authenticated verification from the American College of Healthcare Administrators of current certification in a signed, sealed envelope.
11. Applications are void if requirements for nursing home administrator licensure by reciprocity are not met within one (1) year from the date of Board receipt of this application. **All fees are non-refundable and non-transferable.**

12. Retain a copy of the complete application and supporting documentation for your records. **The Board is not able to provide copies of the application.** Employers may require that you provide them with a copy.
13. All submissions and documentation for agenda items must be received by the Board at the close of business on the Monday of the week preceding the scheduled Board meeting. Materials received after the deadline will be reviewed prior to being placed on the agenda for the next scheduled meeting.
14. Applications must be submitted on single-sided paper.

#### **IMPORTANT INFORMATION**

A nursing home administrator applicant/licensee must notify the Board in writing of any changes in the applicant's/licensee's information within thirty (30) days of their occurrence, including but not limited to any change of address and any name change.

The address of record is where the Board mails your license and any correspondence. **Failure to update your address of record may result in failure to receive a license renewal application.**

The address printed on your license is a PUBLIC RECORD that is available to anyone who requests it. Address changes may be done online at the Board's website [www.mass.gov/dph/boards/nh](http://www.mass.gov/dph/boards/nh) or you may obtain a form online to submit to the Board's office.

Answers to many questions may be found on the Board's website ([www.mass.gov/dph/boards/nh](http://www.mass.gov/dph/boards/nh)). Statutes and regulations governing nursing home administrator licensure may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168 or 617-973-0806.



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**CHECKLIST FOR RECIPROCITY APPLICATION  
NURSING HOME ADMINISTRATOR**

Include this checklist with your completed application:

- Reciprocity Application Form including\*
  - Signed and notarized affidavit
  - 2x2 passport style color photo
  - Signed and notarized Criminal Offender Record Information (CORI) Acknowledgement Form
  
- Fee \$225.00 check or money payable to Commonwealth of Massachusetts\*
  
- Official transcripts for all undergraduate degrees and any other post-secondary degrees indicating the degree and date conferred in **mm/dd/yyyy** format (signed and sealed envelope).\*
  
- Four Completed Reference Forms (signed and sealed envelopes): signed, sealed envelopes\*
  - 3 professional
  - 1 personal
  
- Physician Form (signed and sealed envelope)\*
  
- Resume
  
- Copy of current valid nursing home administrators license.\*
  
- Verification of licensure status from any state or jurisdiction which you now or have previously held any professional license (signed and sealed envelope). \*
  
- Original** report from National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank if you hold, or have ever held, a professional license (signed and sealed).
  
- Documentation of compliance with the required continuing education.
  
- NAB credentialing exam score (signed and sealed envelope).

Application must be submitted on single-sided paper.

**\* NOTE: Applicants with current certification from the American College of Healthcare Administrators may submit the items marked with an \* above and an authenticated verification of ACHA certification.**



**EDUCATION**

9. BACHELOR'S DEGREE SCHOOL NAME/LOCATION: \_\_\_\_\_

\_\_\_\_\_

DEGREE: \_\_\_\_\_ DATE AWARDED: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/dd/yyyy)

***Submit official transcript in a signed, sealed envelope. Transcripts may be mailed directly to the Board. If transcripts were previously submitted with an application for the AIT Program they do not need to be sent again if they were submitted in the past 12 months.***

10. OTHER POST-SECONDARY INSTITUTION(S)/LOCATION(S): \_\_\_\_\_

\_\_\_\_\_

DEGREE: \_\_\_\_\_ DATE AWARDED: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/dd/yyyy)

***Submit official transcript in a signed, sealed envelope. Transcripts must be mailed directly to the Board. If transcripts were previously submitted with an application for the AIT Program they do not need to be sent again if they were submitted in the past 12 months.***

***Please list additional post-secondary institutions on a separate sheet and request that transcripts be submitted directly to the Board as noted above.***

11. NAB EXAMINATION DATE: \_\_\_\_\_ SCORE: \_\_\_\_\_

## VERIFICATION OF OTHER LICENSES/BOARD CERTIFICATIONS

12. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS EVER HELD; INCLUDE ALL STATES AND JURISDICTIONS.

RECIPROCITY APPLICANTS MUST LIST THE STATE WHERE THEY CURRENTLY HOLD A LICENSE(S).

I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.

<u>Issuing State/Jurisdiction</u>	<u>Profession</u>	<u>License/Certification Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**APPLICANTS MUST ARRANGE FOR OFFICIAL DOCUMENTATION OF CURRENT LICENSE STATUS FROM EACH STATE OR JURISDICTION TO BE MAILED DIRECTLY TO THE BOARD.**

## QUESTIONS

***IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.***

13. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?

Yes  No

14. Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes  No

15. Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes  No

16. Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes  No

17. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of \$250 or less was imposed.

Yes  No

18. Have you ever been court martialled or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes  No

**RELEASE**

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Nursing Home Administrators any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Nursing Home Administrators to release information contained in this application in association with its processing.

**AFFIDAVIT OF APPLICANT**

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a nursing home administrator I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice as a nursing home administrator in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure shall be deemed no longer valid if requirements for licensure are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board of Registration of Nursing Home Administrators to deny issuance of a license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

**Attach a recent color 2x2 passport photo**

NOTARY NAME: \_\_\_\_\_

COMMISSION EXPIRES: \_\_\_\_\_

[Seal]

**INCLUDE A NONREFUNDABLE , NONTRANSFERABLE FEE OF \$225.00 (CHECK OR MONEY ORDER ) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS**



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**STATE VERIFICATION FORM**  
**RECIPROCITY LICENSURE REQUEST**

\_\_\_\_\_ has made application for reciprocal licensure in  
*name of applicant*  
 the Commonwealth of Massachusetts. According to the information he or she has filed, the applicant states he or she is currently licensed in your state. Please complete the following and return one (1) copy to the applicant within ten (10) days.

APPLICANT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
 \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER.: \_\_\_\_\_  
*Mandatory*

LICENSE NUMBER.: \_\_\_\_\_ DATE ISSUED : \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

1. Is the above information the same as your records indicate? Yes  No

If no, please explain: \_\_\_\_\_  
 \_\_\_\_\_

2. Was your state the state of the applicant's original licensure? Yes  No

If yes, give date: \_\_\_\_\_  
 If no, what do your records indicate as the state of original licensure? \_\_\_\_\_

3. Did the applicant take a written examination for licensure? Yes  No

If yes, which examination(s): \_\_\_\_\_  
 Exam Series No.: \_\_\_\_\_ Total Raw Score: \_\_\_\_\_ Scale Score: \_\_\_\_\_

4. According to your records, is the applicant in good standing with your Board at this time?

Yes  No

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

5. According to your records, has the applicant ever been disciplined by your Board or any other state agency? Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

6. Was the applicant required to do an Administrator In Training program in your state?

Yes  No

If yes, was program completed? Yes  No

Length of AIT Practicum: \_\_\_\_\_

7. Has the applicant, according to your records, ever been convicted of a felony?

Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

8. Please make any additional comments in the space provided: \_\_\_\_\_

\_\_\_\_\_

*The Board appreciates your cooperation in supplying the information requested. Once you have completed the form please, place it in the envelope provided and sign your name across the envelope seal. Then send it to the applicant.*

CHAIRMAN OR DESIGNATED ADMINISTRATOR: \_\_\_\_\_

Signature

DATE: \_\_\_\_\_ STATE: \_\_\_\_\_

BOARD SEAL:

**ATTENTION:**

**MAKE 4 COPIES OF THE FOLLOWING 2 PAGES**



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**REFERENCE FORM**

You have been requested to provide reference information for \_\_\_\_\_,  
an applicant for registration as a Nursing Home Administrator in Massachusetts under the provisions  
of Section 74, Chapter 13 of the General Laws of this Commonwealth. Pertinent information  
concerning the applicant will be helpful to the Massachusetts Board of Registration of Nursing Home  
Administrators.

In order that the provisions of the licensing law may be effective in safeguarding public health, safety  
and welfare, the Board of Registration of Nursing Home Administrators has been charged with the  
responsibility of limiting the use of the title "Nursing Home Administrator" only to those who are found  
qualified and suitable for that profession. As one of the applicant's references, you are familiar with  
his/her professional work or have knowledge of his/her ability, character and reputation. The Board  
would appreciate information that bears upon the extent of the responsibility borne by the applicant in  
his/her professional work as well as your opinion of his/her professional competence and character.

The Board appreciates your cooperation in supplying the information requested on the enclosed sheet.  
Once you have completed the form, please place it in an envelope, sign your name across the  
envelope seal, and return it to the applicant.

**MASSACHUSETTS BOARD OF REGISTRATION OF NURSING HOME ADMINISTRATORS**

**REFERENCE FORM**

**PLEASE TYPE OR PRINT CLEARLY:**

1. NAME OF APPLICANT \_\_\_\_\_

2. PROFESSIONAL OR OTHER RELATIONSHIP TO APPLICANT \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. NUMBER OF YEARS YOU HAVE KNOWN THE APPLICANT \_\_\_\_\_

4. PLEASE EVALUATE THE APPLICANT IN THE CATEGORIES OF WHICH YOU HAVE PERSONAL KNOWLEDGE:

a. PROFESSIONAL KNOWLEDGE AND EXPERIENCE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b. CHARACTER WITH RESPECT TO HONESTY, INTEGRITY, AND GENERAL CONDUCT: \_\_\_\_\_

\_\_\_\_\_

5. DO YOU RECOMMEND THE APPLICANT FOR LICENSURE AS A NURSING HOME ADMINISTRATOR?

Yes \_\_\_\_\_ No \_\_\_\_\_

If No please attach a detailed written explanation of your reasons for not recommending this applicant.

6. OTHER COMMENTS: \_\_\_\_\_

\_\_\_\_\_

**(Attach an additional sheet of paper, if you wish to make additional comments)**

I hereby certify that the information given above is correct to the best of my knowledge and belief, and opinions expressed above represent my best judgment. I hereby agree to provide further information to the Board if requested to do so.

\_\_\_\_\_  
Name (type or print clearly) Signature

\_\_\_\_\_  
Business Address Date

\_\_\_\_\_  
City/State Zip Code Occupation

\_\_\_\_\_  
Home Address City/State Zip Code



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**PHYSICIAN FORM**

1. NAME OF APPLICANT : \_\_\_\_\_

2. NAME OF LICENSED PHYSICIAN : \_\_\_\_\_

3. ADDRESS OF PHYSICIAN: \_\_\_\_\_  
No. Street Apt. #

\_\_\_\_\_  
City/Town State Zip Code

4. PHYSICIAN STATE LICENSE NUMBER: \_\_\_\_\_  
License Number

\_\_\_\_\_  
Expiration Date

I hereby certify that the above named applicant is in good health and has no mental or physical impairment that would prevent him or her from discharging the responsibilities of a Nursing Home Administrator.

\_\_\_\_\_  
Physician Signature Date

**Once you have completed this form, please place it in an envelope, sign your name across the envelope seal, and return it to the applicant.**