NEW YORK STATE DEPARTMENT OF HEALTH
Board of Examiners of Nursing Home Administrators

Nursing Home Administrator Licensure Application Addendum B

QUALIFYING FIELD EXPERIENCE VERIFICATION

TO BE COMPLETED BY THE APPLICANT
CONSENT TO RELEASE INFORMATION

Last Name | First Name | Middle Initial

By my signature below, I am authorizing the facility/person(s) identified below to provide information and documentation to the Board of Examiners of Nursing Home Administrators to be considered as part of my Nursing Home Administrator Licensure Application.

Signature | Date

TO BE COMPLETED BY THE ADMINISTRATOR-OF-RECORD OR AUTHORIZED REPRESENTATIVE OF HUMAN RESOURCES
QUALIFYING FIELD EXPERIENCE VERIFICATION

This form reflects your knowledge of the applicant's qualifying field experience while employed at the facility indicated. Be sure that the applicant has signed and dated the above "Consent to Release Information" allowing you to make available to the Board any and all information regarding his/her qualifying field experience needed to meet the nursing home administrator licensure qualifications. Please return this completed form, along with any required documentation, **directly** to the New York State Department of Health, Board of Examiners of Nursing Home Administrators, Bureau of Professional Credentialing, 875 Central Avenue, Albany, New York 12206. Questions may be directed to the Bureau of Professional Credentialing at 1-877-877-1827.

Facility Name | Work Site Address

Type of Facility

☐ New York Licensed Nursing Home as defined in Article 28 of the New York State Public Health Law

Operating Certificate #: _____

☐ Out of State Licensed Nursing Home (not in New York)

☐ Other Provider Type (must contain or be associated with a certified nursing home) _____

Applicant Job Title | Dates of Employment (Full-Time: **Minimum** 35 hours per week)

Current Annual Salary: _____ ►►►►► **Supporting documentation must be submitted.**

Applicant Job Responsibilities

During the dates of employment indicated above, the applicant had substantial supervisory responsibility for resident/patient care and participated daily in management decisions that affected the following major department(s) or service area(s) within the facility **(check all that apply and attach an organization chart, along with a Job Description on facility letterhead, signed and dated by the Administrator-of-Record or Authorized Representative of Human Resources). Two or more major services or departments are required.**

☐ Fiscal

☐ Food Services

☐ Nursing

☐ Personnel/Human Resources

☐ Rehabilitation Services including all of:
Physical Therapy
Occupational Therapy
Recreational Therapy
Speech/Audio

☐ Social Services including all of:
Admissions
Discharge Planning
Social Service Program

☐ Support and Safety Services including all of:
Housekeeping
Laundry
Maintenance
Safety

AFFIRMATIONS AND CERTIFICATIONS

I affirm, subject to the penalties for perjury, that the statements made herein and on the accompanying documents have been examined by me and to the best of my knowledge and belief are true and correct.

Name of Authorized Representative | Title

Signature of Authorized Representative | Date