

RE-EXAMINATION APPLICATION FOR NURSING HOME ADMINISTRATOR STATE EXAMINATION

Return this completed form with a check or money order (made payable to NHAP) with the appropriate fees to the following address:

Nursing Home Administrator Program
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416

For a current **Fee List and Detailed Fee Analysis**, please visit our website at: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/NHAPFees.aspx>

APPLICANT'S NAME (Last)		(First)		(M.I.)	SOCIAL SECURITY NUMBER
MAILING ADDRESS (Number)				(Street)	
WORK TELEPHONE NUMBER					
(City)	(County)	(State)	(Zip Code)	HOME TELEPHONE NUMBER	
E-MAIL ADDRESS		DRIVER'S LICENSE NUMBER		DATE OF BIRTH (MM/DD/YYYY)	

Requested State Exam date: _____

Check box only if you require special accommodations during the examination. If special accommodations are required, please provide an explanation below.

CERTIFICATION – IMPORTANT – PLEASE READ BEFORE SIGNING – If not signed, this application may be rejected.

I certify under the penalty of the perjury laws of the State of California that the information I have entered on this application is true and correct to the best of my knowledge. I further understand that any false, incomplete, or incorrect statements may result in denial of this application with the Nursing Home Administrator Program. I understand that if I fail to appear for the examination as scheduled, the fees are non-refundable and non-transferable and will be forfeited.

APPLICANT'S SIGNATURE : _____

DATE SIGNED : _____

APPLICANTS—DO NOT USE THIS SPACE BELOW—FOR NHAP USE ONLY

CASH # _____ NHAP INITIALS _____ AMOUNT _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="font-size: x-small;">STATUS</td> </tr> <tr> <td colspan="2" style="font-size: x-small;"><input type="checkbox"/> Approved <input type="checkbox"/> Rejected <input type="checkbox"/> Denied <input type="checkbox"/> Training Requirements</td> </tr> <tr> <td colspan="2" style="font-size: x-small;"><input type="checkbox"/> AIT #</td> </tr> <tr> <td style="font-size: x-small;">STAFF</td> <td style="font-size: x-small;">DATE PROCESSED</td> </tr> </table>	STATUS		<input type="checkbox"/> Approved <input type="checkbox"/> Rejected <input type="checkbox"/> Denied <input type="checkbox"/> Training Requirements		<input type="checkbox"/> AIT #		STAFF	DATE PROCESSED
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All information requested by the application is required by the California Department of Public Health, Nursing Home Administrator Program. Maintenance of the information requested on this form is authorized by the Health and Safety Code.