



# Preceptor Certification

**Board of Nursing Home Administrators**  
P.O. Box 6330  
Tallahassee, FL 32314-6330  
Website: [floridasnursinghomeadmin.gov](http://floridasnursinghomeadmin.gov)  
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Do Not Write in this Space  
For Revenue Receipting Only

## Preceptor Certification (3010) \$100.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. The application fee is nonrefundable.

### 1. PERSONAL INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

Street/P.O. Box Apt. No. City

State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

Street Apt. No. City

State ZIP Country Work/Cell Telephone

#### EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender:	Male	Race:	Native Hawaiian or Pacific Islander	Hispanic or Latino	White
	Female		American Indian or Alaska Native	Black or African American	Asian
			Two or More Races		

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: \_\_\_\_\_

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

## 2. SOCIAL SECURITY DISCLOSURE

**This information is exempt from public records disclosure.**

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s). 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

**Last Name:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Middle Name:** \_\_\_\_\_

**U.S. Social Security Number:** \_\_\_\_\_

**Social Security Information-** \* Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at [www.ssa.gov](http://www.ssa.gov) or by calling 1-800-772-1213.



Name: \_\_\_\_\_

### 3. APPLICANT BACKGROUND

- A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

\_\_\_\_\_

- B. Do you hold, or have you ever held a license to practice any health-related license(s)?

Yes

No

- C. List all health-related licenses (active, inactive, or lapsed). Attach additional sheets if necessary.

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

- D. Are you currently licensed as a Florida Nursing Home Administrator? Yes No

"If Yes," provide your Florida Nursing Home Administrator license number: \_\_\_\_\_

- E. List in chronological order any employment you have had in skilled nursing facilities in the last five years. Attach additional sheets if necessary.

Name of Business and Address	Employment Dates: From- To (MM/DD/YYYY)	Facility Rating
	to	
	to	
	to	
	to	
	to	

- F. Are you currently the administrator of record for the facility or facilities where the training will be taking place? Yes No

- G. Provide the following information for the facilities of which you are the administrator of record. Attach additional sheets if necessary.

License Type	License #	State of Issuance	Expiration Date (MM/DD/YYYY)

**This information is exempt from public records disclosure.**

#### **4. HEALTH HISTORY**

##### **Physical and Mental Health Disorders Impacting Ability to Practice**

- A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice?      Yes      No
- B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice?      Yes      No

##### **Substance-Related Disorders Impacting Ability to Practice**

- C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice?      Yes      No
- D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse?      Yes      No
- E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse?      Yes      No

**If a “Yes” response was provided to any of the questions in this section, provide the following documents directly to the board office:**

**A letter from a Licensed Health Care Practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

**A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

Name: \_\_\_\_\_

## 5. DISCIPLINE HISTORY

- A. Have you ever had a license disciplined for sexual misconduct or committed any act in any other state that would constitute sexual misconduct?      Yes      No
- B. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action in any state or other jurisdiction?      Yes      No
- C. Have you ever been refused a license to practice, or the renewal thereof in any state?      Yes      No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y   N
				Y   N
				Y   N
				Y   N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A **written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

## 6. CRIMINAL HISTORY

For the question below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question.

Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense?      Yes      No

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y   N
				Y   N
				Y   N

If you responded "Yes" in this section, you must provide the following:

A **written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges, and final results.

**Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

**Completion of Sentence Documents.** You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.



**7. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS**

**IMPORTANT NOTICE:** Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction?      Yes      No

**If you responded "No" to the question above, skip to question 2.**

- a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation?      Yes      No
- b. If "Yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)?      Yes      No
- c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation?      Yes      No
- d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed?      Yes      No
2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?      Yes      No

**If you responded "No" to the question above, skip to question 3.**

- a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?      Yes      No
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, Florida Statutes?      Yes      No

**If you responded "No" to the question above, skip to question 4.**

- a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?      Yes      No
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?      Yes      No

**If you responded "No" to the question above, skip to question 5.**

- a. Have you been in good standing with a state Medicaid program for the most recent five years?      Yes      No
- b. Did termination occur at least 20 years before the date of this application?      Yes      No

Name: \_\_\_\_\_

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)?      Yes      No

- a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan?      Yes      No
- b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE?      Yes      No

**If you responded "Yes" to any of the following questions, provide:**

**A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting.

**Supporting documentation** including court dispositions or agency orders where applicable.

**Documentation for sections 4 and 5 must be sent to the board office at [MQA.NursingHomeAdmin@flhealth.gov](mailto:MQA.NursingHomeAdmin@flhealth.gov) or mailed to:**

**Board of Nursing Home Administrators**  
4052 Bald Cypress Way Bin C-07  
Tallahassee, FL 32399-3257

**Documentation for sections 6 and 7 must be sent to the Background Screening Unit at [MQA.BackgroundScreen@flhealth.gov](mailto:MQA.BackgroundScreen@flhealth.gov) or mailed to:**

**Background Screening Unit**  
Florida Department of Health  
4052 Bald Cypress Way, Bin BSU-01  
Tallahassee, FL 32399

## 8. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

I understand that Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed. Failure to do so may result in action by the board including denial of licensure.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
*You may print this application and sign it or sign digitally.*      MM/DD/YYYY



**Complete verifications must be mailed to:**

**Board of Nursing Home Administrators**  
4052 Bald Cypress Way Bin C-07  
Tallahassee, FL 32399-3257



## **Board of Nursing Home Administrators**

### **Preceptor Training Seminar**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

I have completed the six-hour preceptor training seminar in compliance with Rule 64B10-16.0025, Florida Administrative Code. **Attached is a copy of the certificate of completion.**

Course Completion Date: \_\_\_\_\_  
MM/DD/YYYY

Instructor: \_\_\_\_\_

Sponsored by: \_\_\_\_\_

Have you previously been approved as a Florida Preceptor?      Yes      No

I declare that these statements are true and correct and recognize that providing false information may result in a fine, suspension, or revocation of my license as provided in s. 456.067, 456.072, 468.1745, and 468.1755, Florida Statutes.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY