Version: *June 2025*

STATE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS
P.O. Box 2649
Harrisburg, PA 17105-2649

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(1-833-367-2762)
Fax: (717) 787-7769
Website: www.dos.pa.gov/nursinghome
E- Mail: st-nha@pa.gov

Courier Address:
PA Dept of State, Bureau of Professional and Occupational Affairs
Attn: State Board of Examiners of Nursing Home Administrators
2 Technology Park
Harrisburg, PA 17110-2919

APPLICATION FOR A TEMPORARY PERMIT TO ACT AS A NURSING HOME ADMINISTRATOR

IMPORTANT INFORMATION

Please read the following before proceeding with the Application for a Temporary Nursing Home Administrator Permit:

The Board may issue, without examination, a temporary permit as a nursing home administrator, in the event of unusual circumstances affecting the administration of a nursing home, such as the death, disability, resignation or dismissal of the licensed administrator, or other valid reasons as determined by the Board. Prior to the issuance of a temporary permit, the applicant shall appear before the Board accompanied by the manager, owner or representative of the governing body of the facility in which the applicant will be acting as a nursing home administrator if the permit is issued.

- Applicants must be at least twenty-one years old.
- Applicants must be a citizen of the United States or duly declared their intention of becoming a citizen of the United States.

APPLICATION CHECKLIST

1. ☐ Complete pages 1, 2 and 3 of the application.
2. ☐ Application Fee: $145.00 check or money order made payable to “Commonwealth of PA.”

   PLEASE NOTE THE FOLLOWING:

   * Application fees are not refundable.
   * If your temporary permit is not issued within one year from the date your application is received, you will be required to submit another application fee.
   * A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.
3. ☐ If you answered YES to any of the criminal/disciplinary action questions, please provide accurate details on separate 8 ½” x 11” sheets of paper and provide **certified** copies of court documents.
4. ☐ If any documentation submitted in connection with this application will be received in a name other than the name under which you are applying, you must submit a copy of the legal document(s) indicating the name change (i.e., marriage certificate, divorce decree which indicates the retaking of your maiden name; legal document indicating the retaking of a maiden name, or court order).
5. ☐ If applicable, the Board must receive verification of a license, certificate, permit, registration or other authorization to practice any health-related profession directly from the state or jurisdiction. *PLEASE NOTE: The Board does NOT need to receive verification for licenses issued by one of the licensing boards within the Pennsylvania Bureau of Professional and Occupational Affairs.*
6. ☐ Provide a recent Criminal History Records Check (CHRC) from the state police or other state agency for **every state** in which you have lived, worked, or completed professional training/studies for the past five (5) years. The report(s) must be dated within 180 days of the date the application is submitted. To obtain a Pennsylvania record check, please visit https://epatch.pa.gov .

   (If you reside outside of Pennsylvania, you must contact the State Police from your jurisdiction.)

7. ☐ Submit a copy of one of the following to show highest level of education attained:
    a. High School Diploma
    b. RN License
    c. College Transcript or Diploma
8. ☐ You must provide a copy of your current curriculum vitae/resume.
9. ☐ You must provide a Facility Information for Temporary Permit Request form (page 4 & 5) that is completed by the manager, owner or representative of the governing body of the facility.

ADDITIONAL INFORMATION

Once a completed application is received, you will be scheduled to appear before the Board at its next scheduled meeting and must be accompanied by the manager, owner or representative of the governing body of the facility in which you will be acting as a nursing home administrator if the permit is issued.

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When requesting a Temporary Permit as provided for in the Nursing Home Administrators License Act, Section 14, you must comply with Sections 39.4(3) of the Board's Rules and Regulations.

Application Fee: $145.00 check or money order made payable to the "Commonwealth of Pennsylvania." *Not refundable or transferable.* If your temporary permit is not issued within one year from the date your application is received, you will be required to submit another application fee. A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO OR RECEIVED FROM THE BOARD FOR YOUR FUTURE REFERENCE.

ALL ENTRIES MUST BE LEGIBLE.

1. Name _____
(Last) (First) (Middle)

2. Address _____
(Street)

_____
(City) (State) (Zip Code)

*The address you provide is the address that will be associated with this application to which all correspondence will be mailed. Please note that licenses are **not forwardable.***

3. Telephone _____ Fax _____

4. E-Mail Address _____

5. Date of Birth _____ 6. Social Security Number _____

		YES	NO
7.	Are you a U.S. Citizen? If no, please explain and provide a statement regarding your intention of becoming a citizen of the United States. _____	☐	☐
8.	Will any documentation submitted in connection with this application be received in a name other than the name under which you are applying? If you answered YES, please provide the name or names. Submit a copy of the legal document evidencing the name change (i.e., marriage certificate, divorce decree or court order). _____	☐	☐

		YES	NO
9.	Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction? If you answered YES to the above question, please provide the profession and state or jurisdiction. Please do not abbreviate the profession. _____ _____ **The Board must receive verification of a license, certificate, permit, registration or other authorization to practice any health-related profession** directly from the state or jurisdiction. *PLEASE NOTE: The Board does NOT need to receive verification for licenses issued by one of the licensing boards within the Pennsylvania Bureau of Professional and Occupational Affairs.*	☐	☐
If you answer YES to any of the following questions, provide complete details as well as <u>certified</u> copies of relevant documents to the Board office.		**YES**	**NO**
10.	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	☐	☐
11.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	☐	☐
12.	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	☐	☐
13.	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, include any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	☐	☐
14.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	☐	☐
15.	Do you currently engage in or have you ever engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	☐	☐
16.	Have you ever had your DEA registration denied, revoked or restricted?	☐	☐
17.	Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	☐	☐
18.	Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?	☐	☐
19.	Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	☐	☐

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

Applicant's Statement:

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Applicant's Signature

Date

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FACILITY INFORMATION FOR TEMPORARY PERMIT REQUEST

(To be completed by the manager, owner or representative of the governing body of the facility.)

1. Facility Name _____

   Facility Address _____
   (Street)

   _____
   (City) (State) (Zip Code)

   Facility Telephone _____ Fax _____

2. **Check applicable items:**

   ☐ Hospital
   ☐ Nursing Home

   Number of Beds _____
   Affiliation if any
   Hospital ☐
   Multi Facility Corp. ☐

   Number of beds:
   _____ Extended
   _____ Skilled Care
   _____ Intermediate Care
   _____ Personal Care
   _____ Residential
   _____ Apartments

   Other Services:
   Home Health Care ☐
   Day Care ☐
   Meals-on-Wheels ☐
   Outpatient Therapies ☐
   Other _____

3. Does the facility have in its employ a licensed Nursing Home Administrator at the present time? ☐ Yes ☐ No

4. Date on which administrator's position was vacated. _____

5. Check below the reason for vacancy:

   ☐ Death ☐ Disability ☐ Sudden Resignation ☐ Discharge

   ☐ Other (describe) _____

   _____

6. Provide requested dates for Temporary Permit: From: _____ To: _____

7. Was the facility administered at a prior time by a holder of a Temporary Permit? ☐ Yes ☐ No

   If yes, please explain and give dates: _____

   _____

8. Is it the facility representative's intention that this applicant seek licensure as a Nursing Home Administrator and, thereafter, serve as the facility's administrator? ☐ Yes ☐ No

   If yes, please explain: _____

   _____

9. Please provide a detailed description on what steps have been taken to obtain/search for a licensed Nursing Home Administrator:

   _____

   _____

Facility Representative's Statement

I have been authorized to act for the facility, and certify that the information entered herein above is true to the best of my knowledge and belief. I understand that any misinformation contained herein is cause for revocation of the Temporary Permit.

_____ _____

Facility Representative's Name and Title | Facility Representative's Signature