



THE STATE
of

ALASKA *Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing*

Nursing Home Administrators Program

PO Box 110806, Juneau, AK 99811

Phone: (907) 465-2550

Email: NursingHomeAdministrators@Alaska.Gov

Website: ProfessionalLicense.Alaska.Gov/NursingHomeAdministrators

Nursing Home Administrator License Application Instructions

Only a licensed nursing home administrator may manage, supervise, or be generally in charge of a nursing home, in accordance with 08.70.080. The care provided by a nursing home or licensed hospital providing nursing home care through the use of skilled nursing beds or intermediate care beds shall be supervised by a licensed nursing home administrator. The only license exemptions are for people engaged on July 1, 1980 in managing or administering an Alaska Pioneers' Home or a hospital with skilled nursing beds or intermediate care beds.

To see the full nursing home administrator statutes and regulations, visit ProfessionalLicense.Alaska.Gov/NursingHomeAdministrators.

NURSING HOME ADMINISTRATOR LICENSE

The following must be received by the division before your application for Nursing Home Administrator License can be reviewed:

1. APPLICATION

A signed, completed application (#08-4020, pages 1-5). Applicants must be at least 19 years of age, as required by 12 AAC 46.010(a)(1).

2. FEES

Fees made payable to "State of Alaska."

Nonrefundable Application Fee:	\$125.00
License Fee:	\$250.00
<hr/>	
Total Fees Due:	\$375.00

3. OFFICIAL TRANSCRIPTS

Official transcript of an associate or higher degree in a health care or business-related field sent directly from a college or university accredited by a national or regional accrediting association recognized by the U.S. Secretary of Education to our office, as required by 12 AAC 46.010(a)(2).

4. VERIFICATION OF EXPERIENCE AND TRAINING

Verification of Experience form (#08-4020a) completed by present or past supervisor(s) to document a minimum of 12 months of experience in health care facility management, as required by 12 AAC 46.010(b)(1).

- OR -

Administrator in Training (AIT) Verification form (#08-4020c) completed by your preceptor(s) confirming completion of an AIT program that meets the requirements of 12 AAC 46.041 or was approved by another licensing jurisdiction. **For approval of an AIT program as required in 12 AAC 46.041, this application and the AIT program proposal form (#08-4020b) must be received and approved before beginning the program.**

- OR -

Verification of a valid and active Health Care Services Executive (HSE) credential issued by NAB. You must request NAB send this to Alaska through their system.

5. VERIFICATION OF LICENSURE

Verification of Licensure must be sent directly to the department from each jurisdiction where the applicant holds or has ever held a license to practice as a nursing home administrator. Each verification must include an explanation of any disciplinary action taken against the licensee. Check with each of the state boards you are or have been licensed in for their verification request process. If a state offers primary source verification on their website, that can be accepted as long as the website clearly confirms that it's a primary source verification.

6. PASSING EXAMINATION SCORES

If you have already taken and passed the NHA exam(s) through the National Association of Long-Term Care Administrator Boards (NAB), request through NAB for your scores to be sent to Alaska through their system. You must have passed the required exam(s) in order to qualify for licensure.

- OR -

If you have not yet taken the NHA examinations, you will receive a notification from the State that you've been approved to register and take the NHA and CORE exams through NAB once all other required items have been received and processed. You will register for examination through NAB. You must pass the required exams in order to qualify for licensure. The NHA Information for Candidates Handbook and other helpful exam materials are available at www.nabweb.org.

PROVISIONAL LICENSE

A provisional license may be granted without examination to a person who meets the standards adopted by the department under AS 08.70.050 and who is needed to fill a vacancy in an administrative position, in accordance with AS 08.70.130(a). The provisional license is valid for six months from the date of issue and is nonrenewable. The start date of the six-month license will be the desired start date listed on the letter from the facility and/or the date the license is approved, whichever is later.

The provisional license may be converted to a permanent license if the provisional license holder pays the applicable additional fees and passes the examinations through NAB before documentation within the application goes stale under 12 AAC 02.915. The applicant must notify the department if they wish to proceed in converting from a provisional to permanent license.

The following must be received by the division before your application for Provisional License can be reviewed:

1. APPLICATION

A signed, completed application (#08-4020, pages 1-5). Applicants must be at least 19 years of age, as required by 12 AAC 46.010(a)(1).

2. FEES

Fees made payable to "State of Alaska."

Nonrefundable Application Fee:	\$100.00
Provisional License Fee:	\$125.00
<hr/>	
Total Fees Due:	\$225.00

3. OFFICIAL TRANSCRIPTS

Official transcript of an associate or higher degree in a health care or business related field sent directly from a college or university accredited by a national or regional accrediting association recognized by the U.S. Secretary of Education to our office, as required by 12 AAC 46.010(a)(2).

4. VERIFICATION OF EXPERIENCE AND TRAINING

Verification of Experience form (#08-4020a) completed by present or past supervisor(s) to document a minimum of 12 months of experience in health care facility management, as required by 12 AAC 46.010(b)(1).

- OR -

Administrator in Training (AIT) Verification form (#08-4020c) completed by your preceptor(s) confirming completion of an AIT program that meets the requirements of 12 AAC 46.041 or was approved by another licensing jurisdiction.

- OR -

Verification of a valid and active Health Care Services Executive (HSE) credential issued by NAB. You must request NAB send this to Alaska through their system.

5. VERIFICATION OF LICENSURE

Verification of Licensure must be sent directly to the department from each jurisdiction where the applicant holds or has ever held a license to practice as a nursing home administrator. Each verification must include an explanation of any disciplinary action taken against the licensee. Check with each of the state boards you are or have been licensed in for their verification request process. If a state offers primary source verification on their website, that can be accepted as long as the website clearly confirms that it's a primary source verification.

6. LETTER FROM FACILITY

A signed letter from the facility where the applicant wishes to work stating the facility's need to fill a vacant nursing home administrator position with the desired start date for the applicant.

General Information

APPLICATION PROCESSING:

The average processing time varies by program. When the application is complete and correct, all supporting documents have been received and all fees have been paid, the license may be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review.

LICENSE TERM:

Licenses are issued for a two-year period and expire on December 31 of even-numbered years, regardless of the date of issuance, except licenses issued within 90 days of the expiration date which are issued to the next biennial expiration date. One renewal notice will be sent via email or mail at least 30 days before license expiration to the last known email or mailing address of record. Failure to receive a renewal notice does not relieve a licensee from the responsibility of renewing a license on time.

PROFESSIONAL FITNESS QUESTIONS:

A “yes” response in the application does not mean your application will be denied. If you have responded “yes” to any professional fitness questions, submit an explanation with the charging and closing court documentation showing final disposition of charge(s) (e.g. court records, fitness letters, etc.).

DENIAL OF APPLICATION:

The denial of an application for licensure may be reported to any person, professional licensing board, federal, state, or local governmental agency, or other entity making a relevant inquiry or as may be required by law.

CHANGES TO LEGAL NAMES, EMAIL ADDRESSES AND/OR MAILING ADDRESSES:

It is the applicant's responsibility to notify the division of any changes to legal names, email addresses and/or mailing addresses. The email or mailing address of record will be used to send all official notifications. The name appearing on the license must be your current legal name. The name change notification form is available on the division's website. Changes to email and/or mailing addresses can be submitted through MY LICENSE. (12 AAC 02.900)

CERTIFIED TRUE COPIES:

If any of the required documents will be issued under a former name, indicate on the application and submit marriage license and/or court documents that are notarized as a “certified true copy of the original document”. To obtain a certified true copy, you must present the notary with the original document along with the photocopy. You must write, “I certify this is a true copy of the original document” and sign your name. The notary will compare the original document with the copy and then notarize your signature.

SOCIAL SECURITY NUMBERS:

A U.S. Social Security Number must be on file with the division before a professional license is issued. If you do not have a U.S. Social Security Number, complete the Request for Exemption from Social Security Number Requirement form located at *ProfessionalLicense.Alaska.Gov*, and include required supporting documents as noted on the form. (AS 08.01.060)

PUBLIC INFORMATION:

All information on the application will be available as public record, unless required to be kept confidential by state or federal law.

ABANDONED APPLICATIONS:

An application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known email or mailing address of the applicant, who then has 30 days to submit a written request for a refund of biennial license and other fees paid, if applicable. The application fee will not be refunded. If no request for a refund is received within that timeframe, no refund will be issued, and all fees will be forfeited. (12 AAC 02.910)

STALE DOCUMENTS:

Application forms, authorizations and verifications older than 12 months from the date the document was received by the division will be considered stale; the document must be resubmitted as appropriate before the application will be considered by the division or a licensing board. Application documents include the application documents and verifications of licensure from other licensing jurisdictions. (12 AAC 02.915)

BUSINESS LICENSES:

The status of a professional license will directly impact the status of an associated business license. Renewal applications for business licenses are mailed separately. A professional license does not bypass the need for a business license; if a business license is required, it must be obtained after an initial professional license is issued. For more information about business licenses, visit *BusinessLicense.Alaska.Gov*.

PAYMENT OF CHILD SUPPORT:

If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

STATUTES AND REGULATIONS:

The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*. Centralized statutes and regulations also apply to all professional licenses; those are also available on the division's website. To receive notifications of proposed regulation changes, send a request with your name, email, and the program you want to be updated on to the regulation specialist at the following email: *RegulationsAndPublicComment@Alaska.Gov*. Courtesy notifications of proposed program regulations changes will also be sent to the email address on record.



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NHA

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Nursing Home Administrator License Application

This application may also be used to request approval of an Administrator-in-Training (AIT) Program under 12 AAC 46.041.

PART I Payment of Fees

Application Type:

☐

Permanent License

☐

Provisional License (6 Months)

PART II Payment of Fees

Required Fees:

(Permanent License)

☐

Application and License Fee (\$125 is Non-Refundable)

\$375.00

Required Fees:

(Provisional License)

☐

Application and License Fee (\$100 is Non-Refundable)

\$225.00

PART III Personal Information

Full Legal Name:

Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).

☐

Not Applicable

☐

Other Names Used: _____

Mailing Address:

P.O. Box or Street

City

State

Zip

Contact Phone:

Date of Birth:

EMAIL AGREEMENT: Providing an email address authorizes the division to send you a web authorization code to register with the MY LICENSE self-service portal. If you do not receive a code or the code you received has expired, contact the division. Once registered you may opt-in to receive all official correspondence electronically. Your account can be accessed at any time.

Email Address:

SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.

PART IV Experience and Training

Per 12 AAC 46.010(b), to meet the experience and training requirements for a Nursing Home Administrator license, an applicant must have completed ONE (1) of the following.

☐ I hold a valid and active Health Care Services Executive (HSE) Credential issued by NAB and understand I must request NAB send verification of my HSE credential directly to Alaska.

☐ I have completed an administrator-in-training (AIT) program that met the requirements of 12 AAC 46.041 or was approved by another licensing jurisdiction.

Select ONE (1) of the following **and** supply your training information below:

- ☐ I certify I completed an AIT program that meets the requirements of 12 AAC 46.041 and was pre-approved by the department per 12 AAC 46.041(c).
- ☐ I certify I have completed an AIT program that meets the requirements of 12 AAC 46.041 and was not pre-approved by the department but was completed within 12 months of the date this application per 12 AAC 46.041(d)(1)(A).
- ☐ I certify I have completed an AIT program that was approved by another licensing jurisdiction.

Jurisdiction:

Preceptor Name	Training Location	Program Duration	Start Date	Completion Date

☐ I have completed a minimum of 12 months experience in health care facility management that meet the requirements of 12 AAC 02.010(b)(1) and (c).

Check all of the following **and** supply your 12 months experience below:

- ☐ I certify I have at least 12 months experience in health care facility management under the supervision of a health care facility administrator who can verify my experience, and I earned at least 40 hours of experience each of those months. (The 12 months do not need to be consecutive.)
- ☐ I certify all experience certified above and listed below was in institutional management in a health care facility and included general administration techniques, fiscal management, personnel management, client care issues, physical facility management, federal and state regulations, and public relations.
- ☐ I understand the Verification of Experience form (#08-4020a) is required.

Facility Name	Supervisor (Name & Title)	Start Date	End Date	Total Months of Experience in Health Care Facility Management (at least 40 hours earned per month)

PART V Educational History

List the college(s) or university accredited by a national or regional accrediting association recognized by the U.S. Secretary of Education where you obtained your associate or higher degree in a health care or business-related field as required by 12 AAC 46.010(a)(2)). Official transcripts must be sent directly from the school(s) to the State of Alaska.

Name of Institution	Location (City, State)	Dates Attended (From – To)	Degree Awarded	Date Awarded

PART VI Professional License(s)

List all states or jurisdictions where you hold or have ever held a nursing home administrator license. Have verifications of those licenses sent directly from the jurisdictions to our office.

☐ Check here if none.

State or Jurisdiction	License Number	Issue Date	License Status (Active, Lapsed)	Issued By
				<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
				<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
				<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
				<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity

PART VII Alaska Law

☐ I hereby certify I have reviewed, understand and will abide by the statutes and regulations applicable to my profession (AS 08.70 and 12 AAC 46).

PART VIII Professional Fitness Questions

The following questions must be answered. "Yes" answers may not automatically result in license denial.

For each "yes" response to any question, you must provide an explanation and documentation. Use the letter of explanation form (#08-4752) appended to this application; include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. A separate letter of explanation form must be provided for each "yes" answer documented below. Documentation includes copies of court orders, charging documents, board, or license actions, etc.

The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.

When in doubt, disclose and explain.

- | | | |
|-------|--|---|
| 1. | Have you been convicted of a crime? For purposes of this question, "crime" includes a misdemeanor, felony, or a military offense, including (but not limited to) a conviction involving driving under the influence (DUI) or driving while intoxicated (DWI), driving without a license, reckless driving, or driving with a suspended or revoked license. "Convicted" includes having been found guilty by verdict of a judge or jury, having entered a plea of guilty, nolo contendere or no contest, or having been given probation, a suspended imposition of sentence, or a fine. | <input type="checkbox"/> Yes
<input type="checkbox"/> No |
| <hr/> | | |
| 2. | Have you had a professional license denied, revoked, suspended, or otherwise restricted, conditioned, or limited or have you surrendered a professional license, been fined, placed on probation, reprimanded, disciplined, or entered into a settlement with a licensing authority in connection with a professional license you have held in any jurisdiction including Alaska and including that of any military authorities? | <input type="checkbox"/> Yes
<input type="checkbox"/> No |
| <hr/> | | |
| 3. | Do you have any unresolved complaints or pending disciplinary proceedings related to a professional license in any jurisdiction?" | <input type="checkbox"/> Yes
<input type="checkbox"/> No |
| <hr/> | | |
| 4. | Are you currently suffering from any condition, mental or physical, that impairs your judgment or that would otherwise adversely affect your ability to practice as a nursing home administrator in a competent, ethical, and professional manner? | <input type="checkbox"/> Yes
<input type="checkbox"/> No |
| <hr/> | | |
| 5. | Have you ever secured a license through deceit, fraud, or intentional misrepresentation in any jurisdiction? | <input type="checkbox"/> Yes
<input type="checkbox"/> No |
| <hr/> | | |
| 6. | Have you ever engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities in any jurisdiction? | <input type="checkbox"/> Yes
<input type="checkbox"/> No |
| <hr/> | | |
| 7. | Have you ever advertised professional services in a false or misleading manner? | <input type="checkbox"/> Yes
<input type="checkbox"/> No |
| <hr/> | | |
| 8. | Have you ever sold or furnished a license to another person? | <input type="checkbox"/> Yes
<input type="checkbox"/> No |
| <hr/> | | |
| 9. | Have you ever practiced as a nursing home administrator or used a designation tending to imply that you were a nursing home administrator without a nursing home administrator license under this chapter (not including any practice that is exempt from licensure requirements under AS 08.70.080)? | <input type="checkbox"/> Yes
<input type="checkbox"/> No |

"Yes" Answers

If you answer "yes" to question 4 in addition to your personal statement, you must submit a statement from your health care provider indicating your ability to safely practice. Applications submitted without the appropriate attachments will be considered incomplete and will not be processed.



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NHA

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Nursing Home Administrators Program

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Website: ProfessionalLicense.Alaska.Gov/NursingHomeAdministrators

Signature Page

Applicant Name:		
Alaska License Number (if known):		<input type="checkbox"/> Application in Process

PART IX Agreement

I hereby certify I am the person herein named and subscribing to this application. I further certify I have read the complete application, and I know the full content thereof. I declare all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I understand any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license, registration, certificate, or permit to practice in the state of Alaska.

I further understand it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

Applicant Signature:		Date Signed:	
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Email: NursingHomeAdministrators@Alaska.Gov

Website: ProfessionalLicense.Alaska.Gov/NursingHomeAdministrators

Verification of Experience

Use this form if qualifying based on health care facility management experience under 12 AAC 46.010(b)(1). *Make additional copies of this form, as needed, to verify you have at least 12 months of experience in institutional management in a health care facility.*



Applicant:

Complete the identifying information below and forward a copy of this form to a current or former health care facility administrator(s) who supervised you in the health care institution. The information requested below must be verified by the supervising administrator.

Applicant Name:		Date of Birth:	
Applicant's Signature:		Date Signed:	



Employer/Supervisor:

Complete the information below for the applicant identified above and return the form directly to the Alaska Nursing Home Administrators Program at the email or mailing address listed in the letterhead.

Facility Name where Experience was Gained:			
Physical Address:	P.O. Box or Street	City	State Zip
Applicant Position:		Number of Months Applicant Worked Under Your Supervision:	(At least 40 hours of experience each month required.)
1. Are you or were you the supervisor of the experience verification on this form?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, are you authorized to provide experience verifications on behalf of the above-named facility?			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Did the applicant earn at least 40 hours of experience each month listed above?			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Was this experience earned under the supervision of a health care facility administrator?			<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Was this experience in institutional management in a health care facility that included general administration techniques, fiscal management, personnel management, client care issues, physical facility management, federal and state regulations, and public relations?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature

By my signature below, I certify the above information is true and correct to the best of my knowledge.

Employer/Supervisor/Authorized Individual Signature:		Date Signed:	
Employer/Supervisor/Authorized Individual Printed Name:		Title:	
Agency Name: (if different from facility address)			
Email:		Phone:	



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Administrator in Training (AIT) Program Proposal Form

An applicant for a nursing home administrator license may meet the training and experience requirements of 12 AAC 46.010 by satisfactorily completing an Administrator-In-Training (AIT) program that meets the following requirements:

- (1) be conducted under the guidance and supervision of a preceptor who meets the requirements of 12 AAC 46.051;
- (2) require completion of all the activities and forms provided in the National Association of Long-Term Care Administrator Boards (NAB) National Administrator Residency/AIT Program Manual (2021 Edition);
- (3) consist of at least 1,000 hours of training and education; and
- (4) be completed within two years of the date that the AIT program proposal is submitted to the department.



Applicant:

Complete the identifying information below and forward a copy of this form to a preceptor who meets the requirements of 12 AAC 46.051.

Applicant Name:				
Preceptor Name:				
Anticipated dates of completion for each AIT activity:				
Phase 1.	Phase 2.			
Phase 3.	Phase 4.			
Phase 5.				
By my signature below, I confirm:				
<input type="checkbox"/> I understand this AIT program must be conducted under the guidance and supervision of the listed preceptor and requires completion of all activities and forms provided in the <i>National Association of Long-Term Care Administrator Boards (NAB) National Administrator Residency/AIT Program Manual (2021 Edition)</i> .				
<input type="checkbox"/> I understand this AIT program must consist of at least 1,000 hours of training and education.				
<input type="checkbox"/> I understand this AIT program must be completed within two years from the date this program proposal is submitted to the department to qualify.				
<input type="checkbox"/> I understand I must submit a complete application, including required fees, with or before providing this proposal form.				
Applicant Signature:			Date Signed:	

**Preceptor:**

Complete the information below for the applicant identified above and return this form directly to the Alaska Nursing Home Administrators Program at the letterhead address above.

Preceptor Name:		Preceptor License Number:	
State of Licensure:		Expiration Date:	
Nursing Home where AIT Training is Taking Place:			
By my signature below:			
<input type="checkbox"/> I certify this AIT program will be conducted under my guidance and supervision and will require completion of all activities and forms provided in the <i>National Association of Long Term Care Administrator Boards (NAB) National Administrator Residency/AIT Program Manual (2021 Edition)</i> as required by 12 AAC 46.041(b)(1)-(2).			
<input type="checkbox"/> I certify this AIT program will consist of at least 1,000 hours of training and education.			
<input type="checkbox"/> I confirm I understand this AIT program must be completed within two years from the date this program proposal is submitted to the department to qualify.			
<input type="checkbox"/> I certify I'm currently licensed as a nursing home administrator in the jurisdiction where the listed applicant is completing the training activities; and I'm currently employed in an administrative position in the nursing home where the listed applicant is completing the training activities.			
<input type="checkbox"/> I confirm to fulfill the duties and responsibilities of a preceptor as outlined in the <i>National Administrator Residency/AIT Program Manual (2021 Edition)</i> .			
<input type="checkbox"/> I certify I will conduct a weekly supervisory conference with the listed applicant to monitor their education and activities throughout the duration of the training program.			
Preceptor Signature:		Date Signed:	



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Administrator in Training (AIT) Verification Form

Upon completion of the AIT program, the applicant and preceptor must complete this form, and the preceptor must submit it directly to the division at the email or mailing address listed above.

➔ **Applicant:** Complete the identifying information below and forward a copy of this form to your preceptor who meets the requirements of 12 AAC 46.051.

Applicant Name:			
Preceptor Name:			
By my signature below, I confirm:			
<input type="checkbox"/> This AIT program was conducted under the guidance and supervision of the listed preceptor and included completion of all activities and forms provided in the <i>National Association of Long-Term Care Administrator Boards (NAB) National Administrator Residency/AIT Program Manual (2021 Edition)</i> .			
<input type="checkbox"/> This AIT program consisted of at least 1,000 hours of training and education.			
<input type="checkbox"/> This AIT program was completed within one of the time frames allowed in 12 AAC 46.041:			
<input type="checkbox"/> Within two years from the date the program proposal was submitted to the department.			
- AND/OR -			
<input type="checkbox"/> Not more than 12 months before the date of this form submission.			
Applicant Signature:			Date Signed:

➔ **Preceptor:** Complete the information below for the applicant identified above and return this form directly to the Alaska Nursing Home Administrators Program at the letterhead address above.

Nursing Home where AIT Training Took Place:			
Training Activities Start Date:		Training Activities End Date:	
By my signature below:			
<input type="checkbox"/> I certify this AIT program was conducted under my guidance and supervision and included completion of all activities and forms provided in the <i>National Association of Long-Term Care Administrator Boards (NAB) National Administrator Residency/AIT Program Manual (2021 Edition)</i> .			
<input type="checkbox"/> I certify this AIT program consisted of at least 1,000 hours of training and education.			

- ☐ I confirm this AIT program was completed within one of the time frames allowed in 12 AAC 46.041:
- ☐ Within two years from the date the program proposal was submitted to the department.
 - **AND/OR** -
 - ☐ Not more than 12 months before the date of this form submission.
- ☐ I confirm I fulfilled the duties and responsibilities of a preceptor as outlined in the *National Administrator Residency/AIT Program Manual (2021 Edition)*.
- ☐ I certify I conducted a weekly supervisory conference with the listed applicant to monitor their education and activities throughout the duration of the training program.

Preceptor Signature:

Date Signed:



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PO Box 110806, Juneau, AK 99811

Phone: (907) 465-2550

Email: License@Alaska.Gov

Website: ProfessionalLicense.Alaska.Gov

Letter of Explanation for a Professional Fitness “Yes” Answer

Use this form only to explain and document any professional fitness “yes” answers. A “yes” answer is not necessarily disqualifying but concealing one may be.

Each “yes” answer requires a separate explanation and associated documentation. Submit all relevant documentation with this form, even if you have previously provided it.

- **Explanations** include full details, dates, locations, type of action, organizations or parties involved, and specific circumstances. If the space provided is insufficient, make additional copies as needed.
- **Documentation** includes copies of court orders, charging documents, board or license actions, decisions against your professional certification, satisfaction of consent agreements (fines paid, community service completed, off probation, etc.), and fitness to practice letters (statement from your provider that you are safe to practice if you check “yes” to any of the questions regarding mental or physical health, or drug or alcohol abuse or addiction).
- **Disciplinary actions** may include, but not be limited to, suspension, surrender, revocation, probation, academic probation, reprimand, censure, restricted license, limited license, conditioned license, or letters of counseling, concern, advice, warning, caution, admonishment, or reprimand.

If you have multiple “yes” answers or multiple incidents for any professional fitness question, you must use a separate copy of this form and provide a full explanation and documentation for each incident.

The contents of licensing files are generally considered public records, unless required to be kept confidential by state or federal law.



Write the professional fitness question number you are answering “yes” to in the box.

Location of Incident:		Date of Incident:	
Explanation of Incident: When in doubt, disclose and explain. <i>Make copies as necessary.</i>			

Did you attach all applicable documents associated with this incident?

- ☐ Court Orders ☐ Consent Agreements ☐ Disciplinary Actions ☐ Charging Documents
- ☐ Court Records ☐ Fitness to Practice ☐ All Other Documentation Related to This Incident
- ☐ I have additional incidents for this “yes” answer, or “yes” answers to other Professional Fitness questions and have attached a separate copy of this form for each incident.

Full Name:		Program:	
Signature:		Date Signed:	



THE STATE
of **ALASKA**

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

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Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee:			
Profession Type (e.g., Acupuncture):		License Number (if applicable):	
I wish to make payment by credit card for the following (check all that apply):			AMOUNT
<input type="checkbox"/>	Application Fee:		
<input type="checkbox"/>	License or Renewal Fee:		
<input type="checkbox"/>	Other (fine, exam, etc.):		
1.			
2.			
TOTAL:			

Name (as shown on credit card):			
Mailing Address:			
Phone Number:		Email (Optional):	
Signature of Credit Card Holder:			

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed.

1. Credit Card Number:		All 3 fields MUST be completed. This section will be destroyed after the payment is processed.
2. Expiration Date:		
3. Security Code:		