

Mississippi State Board of Nursing Home Administrators

1755 Lelia Drive, Ste. 305, Jackson, MS 39216

(601) 362-6914

www.msnha.ms.gov

Application Fee \$325.00

Reinstatement Application (1-3 yrs)

License # _____

Personal Information

Mr. / Ms. / Dr. _____
(Circle preferred) (Last Name) (First Name) (Middle Name) (Maiden Name)

(Preferred Name) (Social Security #) (Date of Birth) (Driver License's Number)

(Home Address) (City) (State) (ZIP)

(Home Phone) (Cell Phone) (Home Email Address)

I hereby authorize the Board to release or disclose my home or residence address to any person or party who requests this information until 6/30/2025.

My highest education degree achieved is: _____

Mississippi Nursing Home Facility

Facility Name: _____ Facility Phone: _____

Address 1: _____ Facility FAX: _____

Address 2: _____ Business Email: _____

City/ ZIP: _____ County: _____

Title: _____

Reinstatement Questions – complete and sign

1. Since your license has lapsed, have you been charged either by the United States Government or a State or Local Government for committing any felony or misdemeanor (other than a traffic offense)?
 Yes No If yes, attach full explanation.
2. Are you currently being treated or have you ever been treated for excessive use of alcohol, drugs or narcotics?
 Yes No If yes, attach full explanation.
3. To the best of your knowledge since your license has lapsed, has there been or is there any disciplinary action taken or pending against you by any licensing board or professional society?
 Yes No If yes, attach full explanation.
4. Since being licensed as a nursing home administrator in Mississippi have you been issued a Nursing Home Administrator license in any other state or returned to work in another state under a previously issued license?
 No Yes, list the state(s) _____
(If Yes, submit an Endorsement Questionnaire to the state Board(s) from which you have received a license.)

I, the undersigned, do hereby affirm under penalty of perjury that all statements made and information contained in this application are true and correct to the best of my knowledge and belief. Further, I authorize employers for the past five years to release records to the Board that may be necessary to verify my qualifications for practice as a Nursing Home Administrator.

(Date)

(Signature of Applicant)

Certificate of Employment

I certify that _____ is employed by
(Name of AIT)

_____ as of _____
(Name of Facility) (Effective date of employment)

and will become a full-time, practicing, Administrator-in-Training after being approved by the Mississippi State Board of Nursing Home Administrators.

Owner/Regional Manager/Chairman of the Board
(Printed or Typed)

Signature

Date

Subscribed and sworn to before me this _____ Day of _____, 20____.

_____ my commission expires _____
(Notary Public)

NOTARY SEAL

Administrator-in-Training/Preceptor Agreement

I, _____ have entered into an agreement with
(Administrator-in-Training)

_____ to serve as my preceptor for a period of 12 weeks,
(Preceptor)

beginning _____.
(month - day - year)

I will be an Administrator-in-Training at _____,
(primary facility)

Located at _____.
(address and city)

My Preceptor is at _____,
(facility)

Located at _____.
(address and city)

By affixing our signatures below, both my Preceptor and I agree to follow standards and guidelines set forth by the Board and to submit such periodic and special reports as the Board may require during the period of training.

Signature _____
(Administrator-in-Training) (Date signed)

Signature _____
(Preceptor) (Date signed)

NOTE: Part 2703, Chapter 1, Rule 1.2.C.(1) states:

"A candidate shall be deemed to have abandoned the application if he/she does not begin the A.I.T. Program within ninety (90) days from date of Board approval to enter the Program".

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ENDORSEMENT/RECIPROCITY QUESTIONNAIRE

Applicant: Complete this section and provide a copy of this form to each state board that has issued you a license or to any state board to which you have applied for licensure. Send to ALL states since original licensure.

NAME: _____ HOME ADDRESS: _____

BUSINESS ADDRESS: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

State Licensing Board: This individual, who is or has previously been licensed in your state, has made application for license by endorsement as a Nursing Home Administrator in Mississippi. Please complete the following form and return to the above address. Thank you.

1) Is the above information the same as your records? Yes No

LICENSE NUMBER: _____ DATE ISSUED: _____ DATE EXPIRES: _____

STATUS OF LICENSE: Active Inactive Expired

2) Did your state issue original license? Yes No If **No**, indicate state of original license _____

3) If original license was issued by your state, what was the type of exam? NAB PES Other

Raw Score _____ Scale Score _____ Date of Exam _____

4) If original license was issued by your state, was an A.I.T. Practicum successfully completed?

No Yes Length of practicum: _____

5) Has the applicant ever been disciplined by your Board? No Yes If **Yes**, please explain:

6) According to your records, is the applicant in good standing with your Board at this time? Yes No

If **No**, please explain

7) Does the applicant currently have an investigation or a disciplinary action pending? No Yes

8) According to your records, what is the highest level of education achieved by this applicant? _____

Printed Name of individual completing this form

Signature

Official Title

Date

STATE SEAL

Mailing Address

Phone Number

State of: _____

City, State, Zip Code

Email Address