TEXAS Health and Human Services

Form 5518-NFA
December 2024

Nursing Facility Administrator Program

Provisional Licensure Questionnaire

Section 1: Applicant Information (To be completed by the applicant.)

Note: Email completed forms and documents to the NFA_Licensing_Program. If the state that issued the applicant's license cannot verify education, internship, exam scores and courses in the four domains of the National Association of Long-Term Care Administrator Boards (NAB), it is the applicant's responsibility to submit proof of these items along with this questionnaire.

License Information

Name of Applicant (last, first, middle):		Maiden Name (if applicable):		
Social Security No.:	Date of Birth:	Email Address:		
Street Address:		City:	State:	ZIP Code:
Area Code and Phone No.	State Where Issued:	Nursing Facility Administrator (NFA) No.:		Date Issued:

Employment Information

Applicant must have been employed for at least one year as the administrator of record in the applicant's state.

Name of Employer:			
Street Address:	City:	State:	ZIP Code:

Nursing Facility? ◯ Yes ◯ No

Were you the administrator of record at this facility? ◯ Yes ◯ No

Date of Employment: _____ to _____

Provisional License Sponsor

Name of NFA that will sponsor you during Provisional Licensure:	Sponsor License No.:

Applicant's Authorization and Signature

I, the Applicant, authorize the release of my licensure information from the state I'm currently licensed in.

Applicant Signature: _____ **Date:** _____

Section 2: To be completed by the state where the applicant is currently active. Once completed, return to the applicant.

State Licensed In

License No.:	Date of Issuance:	Expiration Date:

Current Status: ◯ Active ◯ Expired ◯ Revoked ◯ Other: _____

Licensure Basis: ◯ Exam ◯ HSE certification from NAB ◯ Reciprocity ◯ Waiver ◯ Other: _____

Internship

Internship Completion Date:	No. of Hours Completed:

Is the internship part of an NAB-accredited program, including topics and activities described in the NAB-AIT manual? ◯ Yes ◯ No

Does the applicant have a Health Services Executive (HSE) qualification? ◯ Yes ◯ No

If so, can you certify that the applicant has not had a license or HSE qualification revoked in any state? ◯ Yes ◯ No

Education

Bachelor's Degree? ◯ Yes ◯ No

If yes, name of university where degree(s) were completed: _____

Name of Degree(s) Awarded: _____

Did the applicant meet a minimum of 12 semester credit hours in long-term care administration, or its equivalent, that includes courses in the four domains of the NAB? ◯ Yes ◯ No

Master's Degree? ◯ Yes ◯ No

If yes, name of university where degree(s) were completed: _____

Name of Degree(s) Awarded: _____

Did the applicant meet a minimum of 12 semester credit hours in long-term care administration, or its equivalent, that includes courses in the four domains of the NAB? ◯ Yes ◯ No

Examination

NAB Exam Name:	NAB Exam Date:	NAB Official Exam Score:
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State Exam Date *(if applicable)*:		State Exam Passed? ◯ Yes ◯ No

Enforcement History

Disciplinary Actions Taken? ◯ Yes ◯ No If yes, provide more information.

Signature Required

Signature – Representative of the State

Title

Name (Type or Print)

Date

With a few exceptions, you have the right to request and be informed about the information that HHSC obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, and 559.004). Contact the Nursing Facility Administrator to find out about your information and your right to request correction.