

Nursing Facility Administrator (NFA) Program
Provisional Licensure Questionnaire

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.

Section 1 – Applicant Information

To be completed by the applicant.

License Information

Applicant's Last, First and Middle Name		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 Sponsor 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 – State Use Only

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

Name of university where degree(s) were completed, if yes: _____

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

Name of university where degree(s) were completed, if yes: _____

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
NAB Exam Name	NAB Exam Date	NAB Official Exam Score
State Exam Date, if applicable	State Exam Passed? ☐ Yes ☐ No	

Enforcement History

Disciplinary Actions Taken? ☐ Yes ☐ No Provide more information, if yes.

--

Signature Required

Printed or Typed Name _____ Signature of State Representative _____ Date _____ Title _____

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.