STATE OF MAINE

NURSING HOME ADMINISTRATORS
LICENSING BOARD

APPLICATION FOR LICENSURE

- Administrator-In-Training Program
- Temporary Nursing Home Administrator
  - Nursing Home Administrator
- Multi-Level Long Term Care Facility Administrator

Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8626
Office Facsimile: (207) 624-8637
TTY/HEARING IMPAIRED (888) 577-6690
Internet: www.maine.gov/professionallicensing

Office located at: 122 Northern Avenue, Gardiner, Maine 04345

Revised 7/2008
The application material you have requested from the Nursing Home Administrators Licensing Board is enclosed. It contains all the relevant materials you need to complete your application for licensure in the State of Maine. Please read all the information carefully. If you have any questions after reading this packet, please call or e-mail our office.

**FURNISHED TO APPLICANT**

- Application Information Guide
- Individual License Application
- Application for State Examination
- Verification of Licensure Form
- Statement of Need
- Accommodation Request Form
- Documentation of Disability Related Needs
- NPDB/HIPDB Self-query Report Information Sheet

**ADDITIONAL RESOURCES**

- Licensing Law for Nursing Home Administrators
  
  *Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Maine Laws throughout your licensure.*
  
  Available: [http://janus.state.me.us/legis/statutes/32/title32ch2sec0.html](http://janus.state.me.us/legis/statutes/32/title32ch2sec0.html) or call (207) 624-8626

- Licensing Rules for Nursing Home Administrators
  
  *Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Board Rules throughout your licensure.*
  
  Available: [http://www.maine.gov/sos/cec/rules/02/chaps02.htm#371](http://www.maine.gov/sos/cec/rules/02/chaps02.htm#371) or call (207) 624-8626

- Licensing Rules for the Department of Professional and Financial Regulation
  
  Available: [http://www.maine.gov/sos/cec/rules/02/chaps02.htm#041](http://www.maine.gov/sos/cec/rules/02/chaps02.htm#041)

- Statutory Authority, Titles 5 & 10
  
  Available: [http://janus.state.me.us/legis/statutes/10/title10ch0sec0.html](http://janus.state.me.us/legis/statutes/10/title10ch0sec0.html)  
  [http://janus.state.me.us/legis/statutes/5/title5ch0sec0.html](http://janus.state.me.us/legis/statutes/5/title5ch0sec0.html)
APPLICATION PROCEDURE

- Please submit your application materials to the Board by mail or hand delivery to our offices. Fax submissions will not be accepted. If the application you submit to us is complete, it will be reviewed and processed in the order it was received.

- If there are deficiencies with your application, you will be notified by mail.

- Please do not call our office regarding the status of your application. Information regarding the status of applications may be found at the Office of Licensing & Registration's website: http://www.maine.gov/pfr/professionallicensing/license_search.htm. We appreciate your thoughtful attention to this request.

- All material pertaining to an application must be received by the Board within a span of no more than six months. Applications which remain incomplete for more than six months will be disposed of. Candidates whose applications have been incomplete for more than six months will be required to submit new application materials if they seek licensure.

- All name and/or address changes must be submitted to the Board, in writing, either by mail or fax throughout your licensure.
ADMINISTRATOR-IN-TRAINING PROGRAM (AIT)

All applicants applying for an Administrator-in-Training Program (AIT) must submit the following:

- Completed and signed Application; (Pages 7 – 9)
- Payment of an Application Fee of $75.00;
- Payment of an Examination Fee of $75.00;
- Payment of an AIT Fee of $125.00;
- Payment of a Criminal History Records Check Fee of $21.00;

  **Note: All fees can be in one payment.**

- Transcript(s) documenting educational requirements as stated in Board rules Chapter 2, § 1(B);
- Two (2) reference letters indicating the applicant to be of good record and reputation for honest and reliable conduct in personal and business affairs;
- Resume;
- NPDB/HIPDB Self-query Reports;
- Formal Training Guide; and
- Written documentation that the applicant’s Preceptor has completed a Board approved Preceptor Training Program.

A Preceptor as defined in Board Rules shall supervise the AIT program. Please review Chapter 2 of the Board Rules for further information pertaining to application for the AIT Program.

Upon submission of the above requirements, the applicant shall report to the Board, at a regularly scheduled meeting, for the purpose of orientation.

During the AIT program, the applicant shall submit a monthly progress report, which shall provide the Board with a summary of the previous month’s activities, including dates and times of the activities. The Preceptor shall review and sign this report, which shall be submitted to the Board by the 10th of the following month.

Upon completion of the AIT Program and all other necessary requirements, the applicant shall make application for examination in writing on forms provided by the Board. Upon successful completion of both the state and national examinations, the applicant shall be eligible for licensure.
All applicants applying for licensure as a Nursing Home Administrator must have passed both the state and national examinations and must submit the following requirements:

- Completed and signed Application; (Pages 7 – 9)
- Payment of an Application Fee of $75.00;
- Payment of an Examination Fee of $75.00;
- Payment of a Licensure Fee of $200.00;
- Payment of a Criminal History Records Check Fee of $21.00;

  **Note: All fees can be in one payment.**

- Transcript(s) documenting educational requirements as stated in Board rules Chapter 2, § 1(B);
- Two (2) reference letters indicating the applicant to be of good record and reputation for honest and reliable conduct in personal and business affairs;
- Resume;
- NPDB/HIPDB Self-query Reports; and
- Documentation that the applicant has completed a Board–approved AIT Program or be eligible for endorsement as specified in Chapter 6 of the Board Rules.

Upon submission of the above requirements, the applicant shall report to the Board, at a regularly scheduled meeting, for the purpose of orientation. If an applicant is deemed to have met all requirements, they shall be scheduled to sit for the state examination. Upon successful completion of the state examination, they shall be issued a license as a Nursing Home Administrator.

**TEMPORARY LICENSURE**

In order to fill a position that unexpectedly becomes vacant for an Administrator in a facility covered by Board Rules; the Board shall issue a temporary license provided that the applicant has met the requirements as stated in Chapter 7 of the Board Rules.

All applicants applying for temporary licensure must submit the following:

- Completed and signed Application; (Pages 7 – 9)
- Payment of an Application Fee of $75.00;
- Payment of a Licensure Fee of $125.00;
- Payment of a Criminal History Records Check Fee of $21.00;

  **Note: All fees can be in one payment.**

- Two (2) reference letters indicating the applicant to be of good record and reputation for honest and reliable conduct in personal and business affairs;
- Resume;
- NPDB/HIPDB self-query reports; and
- Statement of Need. (Page 13)

Upon submission of the above requirements, the applicant shall report to the Board, at a regularly scheduled meeting for the purpose of orientation.

The temporary license shall be issued for a period not to exceed three (3) months, but it may be renewed for an additional three (3) months at the discretion of the Board, upon demonstration of extreme hardship and in the interest of the public protection.
MULTI-LEVEL LONG TERM CARE FACILITY ADMINISTRATOR

All applicants applying for licensure as a Multi-Level Long Term Care Facility Administrator shall be required to meet the qualifications pertaining to both Nursing Home Administrators and to Residential Care Facility Administrators.

Applicants applying for licensure must submit the requirements pertaining to licensure as a Nursing Home Administrator and in addition, submit documentation that the applicant has demonstrated knowledge of residential care/assisted living by completing one of the requirements stated in Chapter 4, § 1 of the Board Rules.

All applicants applying for licensure as a Multi-Level Long Term Care Facility Administrator must have passed both the state and national examinations.

Upon submission of the above requirements, the applicant shall report to the Board, at a regularly scheduled meeting, for the purpose of orientation. If an applicant is deemed to have met all requirements, they shall be scheduled to sit for the state examination. Upon successful completion of the state examination, they shall be issued a license as a Multi-Level Long Term Care Facility Administrator.

ENDORSEMENT

The Board may endorse, without written national examination, a valid, permanent license issued by the proper authorities of any other state to a Nursing Home Administrator or Multi-Level Long Term Care Facility Administrator, upon payment of the established fee, provided that the applicant has met the requirements as stated in Chapter 6, § 1 of the Board Rules.

All applicants applying for licensure by endorsement must submit the following:

☐ Completed and signed Application; (Pages 7 – 9)
☐ Payment of an Application Fee of $75.00;
☐ Payment of an Examination Fee of $75.00;
☐ Payment of a Licensure Fee of $200.00;
☐ Payment of a Criminal History Records Check Fee of $21.00;

Note: All fees can be in one payment.

☐ Documentation that the applicant has met the requirement for licensure as stated in Chapter 6 § 1 of Board Rules;
☐ Written verification of satisfactory completion of the NAB national examination;
☐ Two (2) reference letters indicating the applicant to be of good record and reputation for honest and reliable conduct in personal and business affairs;
☐ Resume;
☐ NPDB/HIPDB Self-query Reports; and
☐ Completed Verification of Licensure from each state in which applicant holds or has held any certification, licensure, or other credential. (Pages 11 – 12)

Applicants applying for licensure by endorsement must pass the state examination.

Upon submission of the above requirements, the applicant shall report to the Board, at a regularly scheduled meeting, for the purpose of orientation. If an applicant is deemed to have met all requirements, they will be eligible to sit for the state examination. Upon successful completion of the state examination a license will be issued to them for the category in which they are applying.
Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035.

- **Where are you located?** 122 Northern Avenue, Gardiner, Maine.

- **What hours are you open?** 8:00 a.m. to 5:00 p.m. weekdays.

- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.

- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.

- **How can I check the status of my application?** You can check our website: [www.maine.gov/professionallicensing/license_search.htm](http://www.maine.gov/professionallicensing/license_search.htm).

- **How far back do I go answering the criminal conviction question?** Any conviction, ever.

- **Can I fax my application?** No.

**NOTICES**

**BACKGROUND CHECK:** Pursuant to 5 M.R.S.A. §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

**PUBLIC RECORD:** This application is a public record for purposes of the Maine Freedom of Access Law (1 MRSA §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

**SOCIAL SECURITY NUMBER:** The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number Is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRSA §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRSA §191.

Before you seal the envelope, did you:

- Complete every item on the application including the criminal background disclosure question.
- Sign and date your application.
- Include the required fee(s). Make checks payable to “Maine State Treasurer” or complete the credit card section on the application. DO NOT SEND CASH.
- Make a copy of your application to keep for your records.
**STATE OF MAINE**
**DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**
**OFFICE OF LICENSING AND REGISTRATION**
**INDIVIDUAL LICENSE APPLICATION**

**APPLICANT INFORMATION** (please print)

<table>
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<tr>
<th>FULL LEGAL NAME</th>
<th>FIRST</th>
<th>MIDDLE INITIAL</th>
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## CRIMINAL BACKGROUND DISCLOSURE

**NOTE:** Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.

1. Have you ever been convicted by any court of any crime? (circle one)  NO  YES
   - If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.

2. Has any jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one)  NO  YES
   - If yes, enclose a detailed explanation and copies of all documents.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Licensing and Registration will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

**SIGNATURE**

**DATE**

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**Nursing Home Administrators Licensing Board**

**Please Select Type:**

- Multi-Level Long Term Care Administrator (MLA1421)
- Nursing Home Administrator (AD1421)
  - Required Fee: $371 (includes Criminal History Check Fee)
- Temporary License (AT1421)
  - Required Fee: $221 (includes Criminal History Check Fee)
- Administrator-In-Training Program (AIT1421)
  - Required Fee: $296 (includes Criminal History Check Fee)

**Please Check Here for State Examination:**

- Examination (1447)

**Office Use Only:**

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<td>1421 - 125.00</td>
<td>1447 - 75.00</td>
<td>1446 - 75.00</td>
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<tr>
<td>2619 - 21.00</td>
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**PAYMENT OPTIONS:**

Make checks payable to “Maine State Treasurer” - If you wish to pay by Mastercard or Visa, fill out the following:

**NAME OF CARDHOLDER** (please print)

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I authorize the Dept. of Professional and Financial Regulation, Office of Licensing and Registration to charge my

- [ ] VISA
- [ ] MASTERCARD

the following amount: $________

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<th>Expiration Date</th>
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**SIGNATURE**

**DATE**
FACILITY INFORMATION

Facility: ____________________________________________________________
Mailing Address: ____________________________________________________ County: __________________________
Work Telephone: (________ ) ______________________________

EDUCATION

Degree Earned: ___________________________ Date Received: ________________

ADMINISTRATOR-IN-TRAINING

Name of Training Site: ________________________________________________
Address of Training Site: _____________________________________________
Name of Preceptor: ___________________________________________________
Preceptor’s License Number: __________________________ Date of Licensure: __________
Did Preceptor complete a Preceptor Training Program?  ☐ Yes  ☐ No Date of completion: __________
Name of Facility where Preceptor is employed: ___________________________
Length of Training Program ☐ Full-time (Six Months) ☐ Part-time (Twelve Months)
Commencement date: ________________________________________________
Identify additional training sites:  SNF: ___________________________________
                                ICF/MR: ___________________________________
                                Residential Care: ____________________________

TEMPORARY LICENSE

Name of Facility: _____________________________________________________
Mailing Address of Facility: _____________________________________________
Name of License Consultant: ____________________________________________
Consultant’s License Number: __________________________ Date of Licensure: ________________
Name of Facility where Consultant is employed: ___________________________
Mailing Address: _____________________________________________________
Anticipated date of employment as a Temporary Licensee: __________________________

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ENDORSEMENT/RECIPROCITY

Name of state(s) in which you are licensed or have held licenses:

________________________________________  License #: ________________________________

________________________________________  License #: ________________________________

Did you complete a structured Administrator-in-Training Program?  □ Yes  □ No

If yes, name of State: __________________________  Date: ________________________________

Date of original license: ________________________________

DISCIPLINARY HISTORY

Have you ever been excluded from participation in Medicare/Medicaid reimbursement?

□ YES  □ NO

If yes, please enclose a detailed explanation.

AFFIRMATION

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Licensing and Registration will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

________________________________________  Date

Signature of applicant
APPLICATION FOR STATE EXAMINATION

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine’s Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, mailing address and other information listed on this application may be posted on the State’s website.

Name: ____________________________________________

Any other names used: __________________________________________

Social Security Number: ___________________________ Date of Birth: ________________

Mailing Address: ____________________________________________ County: ____________

City: __________________ State: __________________ Zip Code: ____________

Home Telephone: (______) __________ Work Telephone: (______) __________

Facility: ____________________________________________

Mailing Address: ____________________________________________ County: ____________

City: __________________ State: __________________ Zip Code: ____________

Work Telephone: (______) __________

Completion Date of AIT Program (if applicable): __________________________________________
VERIFICATION OF LICENSURE

The applicant listed below is applying for licensure in the State of Maine. The Maine Nursing Home Administrators Licensing Board requests written verification from each state the applicant holds or has held any certification, licensure, or other credential. This is your authority to release any information in your files, favorable or otherwise. Please mail this verification directly to the Maine Nursing Home Administrators Licensing Board at the above listed address.

The section below is to be completed by the applicant and forwarded to the State Board in which you hold or have held certification, licensure, or other credential. Any associated fees are the responsibility of the applicant. If Verification of Licensure is needed for more than one state, please copy form as needed.

Name: ____________________________________________

Mailing Address: __________________________________

City: ______________________ State: __________ Zip Code: __________

License Number: ______________ State: __________ Date of Issue: __________

Signature of Applicant ___________________________ Date __________

This section to be completed by the State Licensing Board where the applicant holds or has held any certification, licensure, or other credential.

Name: ____________________________________________ Date of Birth: __________

Address: _________________________________________ Social Security #: ________________

Home Telephone: ( ) __________________ Work Telephone: ( ) ________________

Education (mark the highest level) □ High School □ College

□ Graduate □ Post Graduate

Type of License held: _____________________________ License number: __________________

State: _________ Date Issued: ___________ Expiration Date: ______________

(continued on next page)
If this is not the state of original licensure, was license issued through reciprocity/endorsement?

☐ Yes   ☐ No   From what state? ______________________

Was this individual licensed on the basis of his/her certification through the American College of Health Care Administrators?

☐ Yes   ☐ No

Status of License:  ☐ Active   ☐ Inactive   ☐ Expired

Exam:  ☐ NAB   ☐ PES   ☐ Other

Score Raw ________ Scale ________ Date of Exam: ________ State: _______

Was an AIT/Practicum successfully completed?  ☐ Yes   ☐ No

If yes, length of AIT/Practicum:  ____________________________________________________

Has the Board ever disciplined the applicant?  ☐ Yes   ☐ No

If yes, please explain:  _______________________________________________________________

_________________________________________________________________________________

Is there any investigation or disciplinary action pending?  ☐ Yes   ☐ No

If yes, please explain:  _______________________________________________________________

_________________________________________________________________________________

Signed  ____________________________________

Printed name and title _________________________

State Seal

State  _________________________________

Date  _________________________________
STATEMENT OF NEED
To be completed for Temporary Licenses only

The position of administrator for ____________________________________________ Facility has become unexpectedly vacant due to the following circumstances:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

The facility does intend to hire ____________________________________________ Name to fill this position with the stipulation that ____________________________________________ Facility will retain the following board approved licensed administrator consultant:

________________________________________ Name

License Number

during the period in which the applicant renders service to the facility under a temporary license.

________________________________________ Owner or Representative of Governing Board

________________________________________ Date
ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.

Name: ____________________________________________
Address: __________________________________________
Telephone #: __________________________ Social Security Number: __________________________

Accommodations Requested for the ______________________ Examination.
Disability _____________________________

Please check all that apply

☐ Accessible Testing Site
☐ Separate Testing Site
☐ Braille
☐ Large Print
☐ Tape
☐ Reader as Accommodation for Visual Impairment
☐ Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
☐ Reader as Accommodation for Learning Disability
☐ Scribe/Amanuensis as Accommodation for Learning
☐ Sign Language Interpreter
☐ Extended Time
  ☐ Time-and-a-half
  ☐ Double time
  ☐ More than double time (specify) ______________
☐ Use of Computer or Other Adaptive Equipment (specify) ______________
☐ Other: ___________________________________________________________________________________

Signed and Dated: __________________________________________________________________________

Name: ____________________________________________________________________________________
Address: __________________________________________________________________________________
Telephone #: __________________________ Social Security Number: __________________________
DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known ______________________________ since ________ in my capacity as a
(Test applicant)                                          (Date)

(Professional title)

The applicant has discussed with me the nature of the test to be administrated. It is my opinion that because of this applicant’s disability, he/she should be accommodated by providing the following: (check all types)

☐ Taped test
☐ Large print test
☐ Reader
☐ Scribe/amanuensis
☐ Extended time
☐ Time-and-a-half
☐ Double time
☐ More that double time (please justify) ____________________________

☐ Separate Testing Area
☐ Use of Computer or Other Adaptive Equipment (please specify) ______________________
☐ Other (please specify) _________________________________________________________

Signed: ______________________________ Title: __________________

Date: __________________ License # (if applicable): ______________________

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National Practitioner Data Bank (‘‘NPDB’’) and Healthcare Integrity and Protection Data Bank (‘‘HIPDB’’)
Self-Query Reports

Pursuant to 10 M.R.S.A. §8003, sub-§10*, the Office of Licensing and Registration will require all applicants to submit a NPDB/HIPDB Self-Query Report as part of the initial application for licensure within each of the following allied health licensure programs effective November 1, 2007. Applications received without the NPDB/HIPDB self-query report will be considered incomplete which will further delay the application process.

* “National disciplinary record system. Within the limits of available revenues, all bureaus, offices, boards or commissions internal or affiliated with the department shall join or subscribe to the national disciplinary record system used to track interstate movement of regulated professionals who have been the subject of discipline by state boards, commissions or agencies and report disciplinary actions taken within this State to that system.”

Alcohol and Drug Counselors
License Alcohol and Drug Counselors
Certified Alcohol and Drug Counselor
Certified Clinical Supervisor
Alcohol and Drug Counselor Aide

Athletic Trainers
Athletic Trainers

Chiropractic Licensure
Chiropractor, Chiropractic Assistant
Chiropractic Acupuncture

Complementary Health Care
Acupuncturist, Naturopathic Doctor,
Naturopathic Acupuncture, Chinese Herbal
Formulation Certification

Counseling Professionals
LP, PC, LMFT, LCPC, RC
Including Conditional

Dietetic Practice
DI, DT / Including Temporary

Hearing Aid Dealers and Fitters
Hearing Aid Dealer and Fitter / Trainees

Massage Therapists
Massage Therapist

Nursing Home Administrators
AD, MLA, RC

Occupational Therapy
OT, OTA / Including Temporary

Physical Therapy
Physical Therapists
Physical Therapists Assistants

Pharmacy
Pharmacist
Pharmacist Technician
Pharmacies
Mail Order Pharmacies
Mail Order Contact Lens Suppliers
Wholesale Distributor
Manufacturer

Podiatric Medicine
Podiatrist, Resident Podiatrist

Psychologists
Psychologist, Psychologist Examiners
Including Conditional and Temporary

Radiologic Technologists
Radiologic Technologists – 3 authorities
Limited Radiographers / Special Permit
Including Temporary

Respiratory Care
Respiratory Therapist
Respiratory Technician
Associate

Social Worker Licensure
LS, LX, LM, LC, MC

SLP and Audiologists
SLP, Audiologist

The instructions to request a self-query report are available at NPDB/HIPDB’s website: www.npdb-hipdb.hrsa.gov. The website includes a Fact Sheet on self-querying, as well as FAQs to assist you in requesting a report. Customer Service Contact information is provided below:

NPDB-HIPDB Customer Service Center
Tel: (800)767-6732
TDD: (703)802-9395

Dated: September 28, 2007