Instructions and Application For
License As An
Assisted Living Residence Administrator

☐ By Examination    ☐ By Endorsement

☐ By Rhode Island Nursing
Home Administrator License

MILITARY STATUS ELIGIBILITY

Please check ONE of the following criteria for expedited application:
☐ I am in active military duty or a reservist
☐ I am a military veteran with honorable discharge
☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name
LAST NAME    FIRST NAME    MI

Phone: (401) 222-2828    TTY/TDD: (800) 745-5555    Fax: (401) 222-1272

Rhode Island Department of Health
Room 104
3 Capitol Hill
Providence, RI 02908-5097

***FOR OFFICE USE ONLY***
Application Approved:
License Number:
Issue Date:
ID#:
Receipt #:
Licensure Requirements

By Examination

☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.

☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of $220.00 and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.

☐ Original BCI check from the RI Attorney General’s Office; if positive BCI, a detailed explanation is required.

☐ Completion of a Department approved training program, which includes:
  • RIALA’s Certificate,
  • RIALA’s letter with examination results, and
  • AIT Certification Form, for 80 hours field experience within a 12 month period in a RI licensed ALR facility; OR

☐ Completion of Degree in health care-related field, which includes:
  • Official school transcript(s), with registrar’s signature and school seal
  • Examination results, and
  • AIT Certification Form, for 80 hours field experience within a 12 month period in a RI licensed ALR facility; OR

☐ Active Rhode Island Nursing Home Administrator license in good standing.
  NHA Number ____________________________

☐ Two original letters of good moral character on company letterhead.

By Endorsement

☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.

☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of $220.00 and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.

☐ A brief history of prior experience in Assisted Living or related industry.

☐ Original BCI check from the RI Attorney General’s Office; if positive BCI, a detailed explanation is required.

☐ Official school or training transcript(s), with registrar’s signature and school seal;

☐ Two original letters of good moral character on company letterhead;

☐ If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)

☐ If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Licensure Information

Please visit the RIDOH website at http://www.health.ri.gov/licenses to Verify your license, download Rules and Regulations/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of $30.00 made payable to RI General Treasurer.

☐ I would like to receive a license certificate. I have enclosed a separate check in the amount of $30.00
1. Name(s)

| Title (i.e., Mr., Mrs., Ms., etc.) | | | | | |
| First Name | | | | | |
| Middle Name | | | | | |
| Surname, (Last Name) | | | | | |
| Suffix (i.e., Jr., Sr., II, III) | | | | | |
| Maiden, if applicable | | | | | |

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

“Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State.”

3. Gender

- Male  - Female

4. Date of Birth

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

5. Home Address

It is your responsibility to notify HEALTH of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Home Phone

Home Fax

Email Address

6. Business Address

(ONLY if it is RELATED to your license.)

This address will appear on the Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Business Phone

Business Fax

Extension
7. Preferred Mailing Address
Please check ONE
- Please use my **Home Address** as my preferred mailing address
- Please use my **Business Address** as my preferred mailing address

8. Qualifying Education
Please list the name and information about the school that you attended that qualifies you for this license.

<table>
<thead>
<tr>
<th>Type of School</th>
<th>Name of School</th>
<th>Date Graduated</th>
<th>Degree Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>University</td>
<td></td>
<td></td>
<td>Bachelor of Arts</td>
</tr>
<tr>
<td>College</td>
<td></td>
<td></td>
<td>Master of Science</td>
</tr>
</tbody>
</table>

9. Other State License(s)
Have you ever held, or do you currently hold, a license in another state?  
- Yes  
- No

If the answer to this question is “yes”, enter all other state licenses in Question 10 (below):

10. Licensure
List all states or countries in which you are now, or ever have been licensed to practice your profession.

<table>
<thead>
<tr>
<th>State/Country</th>
<th>Active</th>
<th>Inactive</th>
<th>State/Country</th>
<th>Active</th>
<th>Inactive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. Criminal Convictions
Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending?  
- Yes  
- No

Abbreviation of State and Conviction (e.g. CA - Illegal Possession of a Controlled Substance):

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Disciplinary Questions
Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined, or are formal charges pending?  
- Yes  
- No

2. Have you ever been denied a license, certificate, registration or permit in any state?  
- Yes  
- No

**Note:** If you answer “Yes” to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use a separate sheet of paper.
I, ________________________________, being first duly sworn, depose and say that I the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as an Assisted Living Residence Administrator in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform HEALTH of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant ___________________________ Date of Signature (MM/DD/YY) ___________________________

Name of Notary (Print, Type or Stamp) ___________________________ Signature of Notary ___________________________

Notary No./Commission No. ___________________________ Commission Expiration Date (MM/DD/YY) ___________________________
ALRA Field Experience Hourly Tracking

**Please Note:** If you are training at multiple facilities, you will need to submit this form in addition to the signed and notarized AIT Certification Form (page 8) from each training Administrator in order to receive credit for your internship hours.

<table>
<thead>
<tr>
<th>Date</th>
<th>Department</th>
<th># of Hours</th>
<th>Residence</th>
<th>Admin. Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sub Total

Rhode Island Assisted Living Residence Administrator Certification - Page 6
Documentation of Eighty (80) Hours of Field Experience  
(AIT Certification Form)

Print/Type Applicant’s Full Name ___________________________________________ Social Security Number __________________________ Date of Birth __________________________

R23-17.4-ALA “Rules and Regulations for the Certification of Administrators of Assisted Living Residences” - Section 3.0, “Qualifications for Licensure” - requires successful completion of a degree in a healthcare related field from an accredited college or university and requires satisfactory completion of a field experience of at least eighty (80) hours, within a twelve (12) month period, in a training capacity in a licensed assisted living/nursing facility that shall include training in the following areas: Administration, Nursing, Activities Department, Admissions, Human Resources, Business Office, Dietary Department, Environment/Maintenance and Housekeeping/Laundry. At the conclusion of the field experience, the administrator of the licensed assisted living/nursing facility where the field experience was performed must attest that the training included each area.

I hereby attest that ______________________________ has satisfactorily completed eighty (80) hours of Field Experience in the following areas:

- [ ] Administration
- [ ] Nursing
- [ ] Human Resources
- [ ] Activities Department
- [ ] Admissions
- [ ] Dietary Department
- [ ] Environment/Maintenance
- [ ] Housekeeping/Laundry
- [ ] Business Office
- [ ] Other, Explain: ____________________________

Total number of hours in AIT Training Program (if hours are obtained at more than one facility, please make photocopies of this form)

Name of Rhode Island Assisted Living Residence Facility __________________________

Signature of Rhode Island Assisted Living Residence Administrator __________________________ Print or Type Name of ALRA __________________________

Date of Signature __________________________ RI ALRA License Number __________________________

The foregoing instrument was acknowledged before me this __________ day of _________________, 20______, by _______________________________,

who is personally known to me or has produced _________________________________
as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp) __________________________ Signature of Notary __________________________

Notary No/Commission No. __________________________ Commission Expiration Date (MM/DD/YY) __________________________
INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as an Assisted Living Residence Administrator in the State of Rhode Island. The Rhode Island Board of Assisted Living Residence Administrator Certification requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Assisted Living Residence Administrator Certification at the above address.

<table>
<thead>
<tr>
<th>Print/Type Full Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Names Used</td>
<td>Social Security Number</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>License Number</td>
<td>Date issued</td>
<td></td>
</tr>
</tbody>
</table>

**THIS SECTION TO BE COMPLETED BY THE ASSISTED LIVING RESIDENCE BOARD**

<table>
<thead>
<tr>
<th>Assisted Living Residence Administrator Program Completed:</th>
<th>Location:</th>
<th>Graduation Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed by Examination? Yes No</td>
<td>Applicant has completed and passed the National Certification Exam: Yes No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>License Status: Yes No</th>
<th>Active</th>
<th>Inactive</th>
<th>Lapsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Date Issued:</td>
<td>Expiration Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Questions:

1. Has this licensee ever been investigated by your Board? Yes No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? Yes No
3. Has the applicant’s license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
4. Do you know of any information that may discredit this person? Yes No

If you answer “Yes” to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Certification:**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type or Print Name</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
</tbody>
</table>

Full Name and State of Licensing Board

Please return directly to HEALTH at the above address. Thank you for your prompt cooperation.