California Department of Public Health (CDPH)
Nursing Home Administrator Program (NHAP)
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416
(916) 552-8780 FAX: (916) 636-6108
NHAP@cdph.ca.gov

DECLARATION AND REQUEST FOR REPLACEMENT LICENSE

Return this completed form with a check or money order (made payable to NHAP) with the appropriate fee to the following address:

Nursing Home Administrator Program
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416

For a current ***Fee List***, please visit our website at: www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/NHAPFees.aspx

Applicant's Name (Last)	(First)	(M.I.)	Social Security Number*
Mailing Address (Number) (Street)			Work Telephone Number
Address for Public Record (Number) (Street)			(City)
(County)	(State) (Zip Code)		Home Telephone Number
Email Address	License Number		Date of Birth

*Social Security Number Disclosure: Pursuant to Section 666(a)(13) of Title 42 of the United States Code and California Family Code Section 17520, subdivision (d), the California Department of Public Health (CDPH) is required to collect social security numbers from all applicants for nursing home administrator licenses. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support orders upon request by the Department of Child Support Services, collection of delinquent State taxes if applicant appears on the Franchise Tax Board's top 500 delinquent taxpayers list pursuant to Business Codes Section 494.5 Subdivision (4) and for reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR, Section 61.1 *et seq.* Failure to provide your social security number will result in the return of your application. Your social security number will be used by CDPH for internal identification, and may be used to verify information on your application, to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.

REQUESTING:

- ☐ Replacement NHA Wall Certificate
- ☐ Replacement Preceptor Wall Certificate
- ☐ Replacement C.E. Provider Wall Certificate
- ☐ Replacement C.E. Provider Certificate

REASON FOR REQUEST:

- ☐ Lost
- ☐ Address Change
- ☐ Status Change
- ☐ Name Change
- ☐ Stolen
- ☐ Active**
- ☐ Original License or Certification Not Received (no fee if within two (2) months)
- ☐ Mutilated
- ☐ Inactive
- ☐ Original License or Certification Not Printed Correctly (no fee required)
- ☐ Destroyed

****A status change to "Active" requires copies of continuing education certificates.**

*****CERTIFICATION – IMPORTANT – PLEASE READ BEFORE SIGNING – If not signed, this application may be rejected.**

I certify under the penalty of the perjury laws of the State of California that the information I have entered on this application is true and correct to the best of my knowledge. I further understand that any false incomplete or incorrect statements may result in denial of this replacement license application by the NHAP. I fully understand that the NHAP may require additional documentation prior to approving and issuing a duplicate license.

APPLICANT'S SIGNATURE***	DATE SIGNED***

APPLICANTS—DO NOT USE THIS SPACE BELOW—FOR NHAP USE ONLY

CASH # _____

NHAP INITIALS _____

AMOUNT _____

STATUS ☐ Approved ☐ Rejected ☐ Denied	
☐ Missing Information	☐ Fee
☐ Name Change Affidavit	
STAFF	DATE PROCESSED