

NC Dept of Health and Human Services
Division of Health Service Regulation
Adult Care licensure Section
2708 Mail Service Center
Raleigh, NC 27699-2708
Tel. 919/855-3765; Fax 919/733-9379

Assisted Living Administrator Certification Application

NAME OF APPLICANT _____
MAILING ADDRESS _____
E-MAIL ADDRESS _____ PHONE () _____
FAX () _____
BIRTHDATE _____

Are you or your spouse an official or employee of the Department of Health and Human Services or of any county department of social services, or a member of the Medical Care Commission, of any county board of Social Services, or of any board of county commissioners? [] YES [] NO

EDUCATION

Circle Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED

College 1 2 3 4 Grad School 1 2 3 4 Degree(s) _____
Other? _____

WORK HISTORY (May attach resume.)

Current Employer: _____

Address: _____

Job Title: _____ Dates Employed _____

Employer: _____

Address: _____

Job Title: _____ Dates Employed: _____

Employer: _____

Address: _____

Job Title: _____ Dates Employed _____

Employer: _____

Address: _____

Job Title: _____ Dates Employed: _____

I certify that I have given true, accurate and complete information on this form or any attachments to the best of my knowledge. I authorize investigation of statements made in this report and understand that false information may be grounds for disqualification.

Signature

Date