

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: (____) _____

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

Have you been a resident of the State of North Carolina for less than 5 years? [] YES [] NO

If you checked "Yes," please state the number of years you have been a resident of the State of North Carolina? _____.

If you have been a resident of the State of North Carolina for less than 5 years, please list all of your former addresses over the past 5 years (If more than 3 addresses, please submit on additional paper)

Address: _____ Length of Time: _____

Address: _____ Length of Time: _____

Address: _____ Length of Time: _____

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: _____

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

DHSR/AC 4604 (Rev. 08/13) NCDHHS