APPLICANT INFORMATION

This form must be completed by all applicants for a facility license, (i.e., all individuals, each partner in a partnership, or chief executive officer or authorized representative in a corporation.) If more space is required, attach additional sheet. Type or print clearly.

IDENTIFYING INFORMATION

NAME	SOCIAL SECURITY NUMBER * (VOLUNTARY FOR I.D. ONLY)	SEX (M/F)	ARE YOU 18 YEARS OR OLDER?
TITLE	DRIVER'S LICENSE NUMBER VALID ☐ Yes ☐ No	PLACE OF BIRTH	
ADDRESS		(AREA CODE) TELEPHONE NUMBER ( )	
OTHER NAME(S) USED BY APPLICANT			

EDUCATION

Check highest completed grade: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐

NAME AND LOCATION OF HIGH SCHOOL			DATE COMPLETED	GED DATE

NAME AND LOCATION OF COLLEGE	COURSE STUDY	YEARS COMPLETED	DEGREE	DATE COMPLETED
		1 ☐ 2 ☐ 3 ☐ 4 ☐		
		1 ☐ 2 ☐ 3 ☐ 4 ☐		

REFERENCES

PERSONAL: *(PLEASE GIVE REFERENCES, INCLUDING PRESENT AND PAST EMPLOYERS,* ***WITH KNOWLEDGE OF YOUR ADMINISTRATIVE ABILITY.)***

NAME	ADDRESS	RELATIONSHIP	TELEPHONE
1.			
2.			

FINANCIAL: *(PLEASE GIVE REFERENCES WITH KNOWLEDGE OF FINANCIAL RESOURCES AND BUSINESS PRACTICES.)*

NAME	ADDRESS	RELATIONSHIP	TELEPHONE
1.			
2.			

PRIOR LICENSURE STATUS

A. HAVE YOU EVER BEEN A LICENSEE OR CO-LICENSEE OF A RESIDENTIAL CARE FACILITY FOR THE ELDERLY, COMMUNITY CARE, CHILD CARE OR HEALTH FACILITY? ☐ YES ☐ NO *IF YES,, COMPLETE C AND D BELOW.*

B. HAVE YOU EVER HELD A BENEFICIAL OWNERSHIP OF 10% OR MORE IN A RESIDENTIAL CARE FACILITY FOR THE ELDERLY, COMMUNITY CARE, CHILD CARE OR HEALTH FACILITY OR BEEN AN ADMINISTRATOR, GENERAL PARTNER, CORPORATE OFFICER, OR DIRECTOR OF ANY SUCH FACILITY? ☐ YES ☐ NO *IF YES, COMPLETE C AND D BELOW:*

C. NAME AND ADDRESS OF FACILITY — EFFECTIVE DATES OF LICENSURE _____ TO _____ — FACILITY TYPE

D. WERE ANY DISCIPLINARY ACTIONS TAKEN?
☐ YES ☐ NO *IF YES, PLEASE EXPLAIN:*

BUSINESS EXPERIENCE

A. HAVE YOU OWNED OR OPERATED ANY BUSINESS? ☐ YES ☐ NO *IF YES, COMPLETE THE FOLLOWING:*

Type	Number of Employees	Your Title	Date Started	Date Ended	Reason for End

B. DO YOU HAVE A PROFESSIONAL LICENSE OR CERTIFICATE? ☐ YES ☐ NO *IF YES, COMPLETE THE FOLLOWING:*

Type	Period Held	Issuing Agency

C. ARE YOU A MEMBER OF ANY PROFESSIONAL/TECHNICAL ASSOCIATION? ☐ YES ☐ NO *IF YES, COMPLETE THE FOLLOWING:*

Association Name	Address

WORK EXPERIENCE. BEGIN WITH YOUR MOST RECENT WORK EXPERIENCE. LIST ALL EXPERIENCES AND PERIODS OF UNEMPLOYMENT IN THE LAST SEVEN YEARS. INCLUDE WORK EXPERIENCE FROM MORE THAN SEVEN YEARS, IF NECESSARY.

Dates	Name and Address of Employer	Basic Duties	Termination Reason
FROM			
TO			
FROM			
TO			
FROM			
TO			
FROM			
TO			
FROM			
TO			

PERSONAL INFORMATION

A. Do you have any physical, mental, or medical condition that could impair your ability to care for the type of resident/client for whom you have requested licensure?

☐ YES ☐ NO *If yes, please explain:*

I DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS FORM ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE	COUNTY WHERE SIGNED	DATE

* Federal law (at Title 5 United States Code Section 552a Note) states that:
Any Federal, State, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.