State of Illinois
Illinois Department of Public Health

Long-Term Care Facility - Administrator Form

Important Notice: The state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act 83-1530 or Public Act 82-567. Disclosure of this information is mandatory. Please mail this form with an original signature to: LTC-QA, 525 West Jefferson, 5th FL, Springfield, IL 62761.

I. GENERAL FACILITY INFORMATION

Facility Name (30 Characters Max) _____

Complete Street Address _____

City _____ ZIP Code _____

II. INDIVIDUAL INFORMATION

Name (Last) _____ (First) _____ (MI) _____

Facility E-Mail Address (Required) _____

Start Date as Administrator of the above named facility _____

III. LICENSURE INFORMATION

Are you an Illinois licensed nursing home administrator?

☐ Yes License Number _____ Expiration Date _____ * Attach Photocopy of License

☐ No * Attach a copy of the application submitted to the Illinois Department of Financial and Professional Regulation.

Are you currently listed as the administrator of any other facility?

☐ No ☐ Yes If Yes, please complete the following:

			Hours Worked From:	To:
Facility Name	_____	City _____	_____	- _____
Facility Name	_____	City _____	_____	- _____
Facility Name	_____	City _____	_____	- _____
Facility Name	_____	City _____	_____	- _____

IV. DECLARATIONS/SIGNATURES

I declare that I have examined this application, including attachments, accompanying documents and statements and, to the best of my knowledge and belief, the information is true, correct and complete. I understand any omissions or misstatements of material facts may jeopardize the facility qualifying for a long-term license.

Signature _____

Date _____