



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:

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

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 _____