

**North Carolina State Board of Examiners
For Nursing Home Administrators**

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Raleigh NC 27612

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FACILITY SURVEY FOR ADMINISTRATOR-IN TRAINING PROGRAM

Name of Facility _____

Address _____

Number of Nursing Facility Beds _____

Medicare _____ Medicaid _____

Regular License for Facility _____

Conditional _____

(If so, submit copy of conditions)

At this time, I certify that no revocation proceeding, suspension of admissions or provisional license has been initiated or issued against the facility.

Signed _____

Administrator

License #

Administrator-in-Training

Date