

**STATE OF NEVADA  
BOARD OF EXAMINERS  
FOR LONG TERM CARE ADMINISTRATORS**

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E-mail: [beltca@beltca.nv.gov](mailto:beltca@beltca.nv.gov)  
Website: <http://beltca.nv.gov>

**CHANGE/ADDITION OF FACILITY**

**\*\*\* IMPORTANT \*\*\***

**Remember, your license belongs to you! By assuming the position of named administrator of a facility, you accept the total responsibility of insuring the proper operations of the facility at all times.**

Please be reminded that NAC 654.181 provides that each person licensed as a nursing facility administrator or an administrator of a residential facility for groups shall notify the Board in writing any time he/she changes his/her contact information including home address, phone number, cell phone number and email address or changes his/her affiliation with a facility within 15 days after such an event. A Licensee will be subject to a fine of \$500.00 for a first offense if the above rule is not adhered to.

Effective February 20, 2013, NAC 654.250.6 requires a nursing facility administrator or an administrator of a residential facility for groups to surrender and return a license to the Board not later than 15 calendar days after terminating his or her affiliation with a named facility for any reason. Licensees will be subject to a fine of \$500.00 for the first violation and at least \$1,000.00 for a second or subsequent violation, but will not exceed \$10,000 for each violation.

**Requests for licenses naming a facility cannot be issued until the license from the previous administrator is received by BELTCA.**

A fee of **\$100.00** is required for the issuance of a new license for each new facility and/or a new license.

The signature of the facility owner or owner's representative is required for all new facilities requested by a licensee.

**PLEASE PRINT LEGIBLY AND PROVIDE COMPLETE INFORMATION.**

LICENSEE NAME \_\_\_\_\_ LICENSE NO. \_\_\_\_\_

\_\_\_\_\_  
(Home Street Address) (City, State, Zip)

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ PERSONAL E-MAIL \_\_\_\_\_

NAME OF NEW FACILITY \_\_\_\_\_ FACILITY LICENSE NO. \_\_\_\_\_ NO.OF BEDS \_\_\_\_\_

\_\_\_\_\_  
(Street Address) (City, State, Zip)

TEL. NO. \_\_\_\_\_ FAX NO. \_\_\_\_\_ FACILITY E-MAIL \_\_\_\_\_

A CHANGE APPLICATION WAS SUBMITTED TO HCQC ON \_\_\_\_\_ COPY ATTACHED.

SIGNATURE OF LICENSEE \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

AUTHORIZED BY: \_\_\_\_\_

*Signature of Facility Owner or Owner Representative*

\_\_\_\_\_  
*Print Name and Title*