AMERICAN COLLEGE OF HEALTHCARE ADMINISTRATORS

Affidavit

Since I have been employed in an Assisted Living/Skilled Nursing or related environment:

☐ I have ☐ have not had a professional license suspended.
☐ I have ☐ have not read and acknowledged the ACHCA Code of Ethics.
☐ I have ☐ have not been charged with an ethics violation.
☐ I have ☐ have not been convicted of a crime. *If you checked "have" for any of the above, except for the Code of Ethics, explain on a separate sheet of paper.* I understand that in the future, if any of the above actions should occur, I am required to notify the Professional Advancement Committee. I understand that this application and related documents are confidential properties of the Professional Advancement Committee and the undersigned. Through my signature below, I agree to allow the Professional Advancement Committee to use this information for bona fide purposes related to facilitating state licensure reciprocity or accredited university assessment of academic equivalency. I recognize that such action may cause this application and related material to become public information in connection with matters involving state licensure reciprocity. Through my signature, I attest to the accuracy of the information on this application, and I understand that this application can be denied, or my Certification revoked, if any answers are falsified. I also agree to be bound by the Professional Advancement Committee of ACHCA Professional Practice and Disciplinary Procedures, as the same may be amended from time to time by ACHCA, including without limitation the arbitration and discipline provisions therein.

Signature _____ Date _____

Experience/Employment Verification

Employment and/or experience of the candidate for *first time* Professional Certification must be verified. The form below must be completed by a supervisor or executive of the organization in which the candidate is/was employed. This form also verifies that the candidate has a minimum of two years experience and that the candidate is recommended for Certification.

Name of Certification Candidate: ☐ Check here if employer is funding your Certification

Last Name First Name

_____ _____

Years of experience the candidate has as an Administrator/Manager in

☐☐ Skilled Nursing ☐☐ Assisted Living

I verify that the above-mentioned candidate is/was employed in an Administration/Management level position as an ___AL ___SNF administrator. To the best of my knowledge, this person has the number of years of experience as identified above.

Signature _____ Date _____

Name of supervisor/executive completing this verification:

Last Name First Name MI

_____ _____ ___

Title

_____

Organization

_____

Address

_____

_____

Phone

_____ - _____ - _____

If not currently employed, date of last employment

____-____-_____ NA ☐