



**GEORGIA BOARD OF NURSING HOME ADMINISTRATORS**  
237 Coliseum Drive \* Macon, Georgia 31217  
Phone (478) 207-2440  
[www.sos.ga.gov/plb/nursinghome](http://www.sos.ga.gov/plb/nursinghome)

**APPLICATION FOR APPROVAL AS A  
NURSING HOME ADMINISTRATOR-IN-TRAINING (AIT)**

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Nursing Home Administrators in the State of Georgia. Visit the website for information

**The Board will not process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all required information and documentation is complete and correct. An incomplete application will result in delayed processing. Incomplete applications are void after one year and will result in a new application and fee.**

Application Checklist

Please use this checklist to ensure that you submit a **COMPLETE** application.

The **\$225.00** application fee is **NON-REFUNDABLE**; Make payable to the **Georgia Board of Nursing Home Administrators**. Fee must be included with application. **Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.**

<b>SECURE &amp; VERIFIABLE DOCUMENT</b>	Changes to Georgia Law (OCGA 50-36-1) provide that <b>all applicants for licensure</b> MUST provide a "Secure & Verifiable Document" and an "Affidavit of Citizenship" with their application. The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "not later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary. <b>ALL APPLICANTS FOR NHAT APPROVAL MUST PROVIDE THIS DOCUMENTATION OR THE APPLICATION WILL NOT BE PROCESSED.</b>
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- BACKGROUND INFORMATION:** All questions must be answered. Any question answered "yes" requires further documentation to be submitted. Attach a letter of Explanation if you have had any arrests, criminal convictions, charges, or sanctions by another state licensing board. You must also submit a certified copy of the court's final disposition, or the official document indicating the current status of the sanction or disciplinary action(s). Approval of licensure is at the Board's discretion.
- EDUCATION:** Submit an official copy of your college transcript or a copy of your High School Diploma. Official Transcripts only will be accepted, no student copies, and must indicate the degree awarded and date degree was conferred.
- AIT Applicants must indicate on this application a current Board approved Nursing Home Administrator Preceptor and Board approved Facility Training Site, OR, that applications have been/will be submitted for Board approval for a new Nursing Home Administrator Preceptor and a new Board approved Facility Training Site (or a Reinstatement application of a prior approval).

- PROGRAM OUTLINE FORM: The Preceptor of the AIT must complete and submit the Program Outline Form with the AIT's application. If the Board approves a different length for the program, the Preceptor will be notified in writing so that a corrected outline can be submitted to the Board.
- In accordance with Board rule's 393-3-.02, the length of the AIT, Internship or work experience is defined according to the level of educational requirements that are met. **Only Board approved Georgia AIT programs are acceptable.**
- DOCUMENTATION COMPLETION FORM: Once the AIT program is complete, the Preceptor will submit to the Board the Certification of Completion form along with the final monthly report due from the AIT to the Board.

\*\*\*\*\* **NEW - VERY IMPORTANT – PLEASE READ CAREFULLY** \*\*\*\*\*

**Upon completion of the AIT program, and the approval by the Board of the AIT Program Completion Report, the AIT shall submit an Application and the required fee for licensure as a Nursing Home Administrator within thirty (30) days of the Board's approval of the AIT program completion.**  
**Once received and approved, the AIT will be eligible to register and sit for the Exam:**

NATIONAL ASSOCIATION OF BOARDS (NAB) EXAM: All AIT applicants must pass the NAB Nursing Home Administrators Licensing Examination to obtain licensure as a Georgia Nursing Home Administrator. Upon approval by the Board to register, the applicant must contact NAB for the purpose of registering to take the examination. Once the examination has been taken the Georgia Board is notified of each applicant's score.

If passed, then a license may be issued if all other licensure requirements are met. If failed, the examination can be retaken. In order to register to retake the examination, the applicant contacts NAB as previously instructed. For additional information regarding this exam, please go to [www.nabweb.org](http://www.nabweb.org).

Failure to take and pass the exam within six months of the date of approval by the Board of the NHA application for licensure shall require the submission of a new application and fee.



**SUPERVISION:** The AIT program may be Full Time or Part Time. Will you be in program on a full time basis (40 hours per week) \_\_\_\_\_ or part time basis (no less than 24 hours per week)? \_\_\_\_\_

### Supervision Chart

Full Time or Part Time	Check next to Length of Program Required
<p style="text-align: center;"><b>Full Time = <u>40 hours/wk</u></b>                      500 hours = 12.5 weeks @ 40 hrs.                      1000 hours = 25 weeks @ 40 hrs.                      1500 hours = 37.5 weeks @ 40 hrs.                      2000 hours = 50 weeks @ 40 hrs.</p>	<p>1. 500 Hours      _____ 3 month license                      2. 1000 Hours    _____ 6 month license                      3. 1500 Hours    _____ 12 month license                      4. 2000 Hours    _____ 12 month license</p>
<p style="text-align: center;"><b>Part Time = <u>24 hours minimum/wk</u></b>                      500 hours = 20.83 weeks @ 24 hrs.                      1000 hours = 41.66 weeks @ 24 hrs.                      1500 hours = 62.5 weeks @ 24 hrs.                      2000 hours = 83.33 weeks @ 24 hrs.</p>	<p>1. 500 Hours      _____ 3 month license                      2. 1000 Hours    _____ 6 months license                      3. 1500 Hours    _____ 12 months license                      4. 2000 Hours    _____ 12 months license</p>
<p>An AIT approval is granted for a <b>3 month, 6 month or 12 month (1 year) period</b>. Written request for an extension must be submitted at least 30 days before approval expires. Approval of reports or extensions is at the Board's discretion.</p>	<p><b>NOTE:</b> If AIT does not submit reports showing proper hours worked, a denial will be issued. If time off is granted during AIT, it must not affect the completion of the program and it must be documented on the monthly reports.</p>

***Applicant must indicate a currently Board approved Preceptor and facility Training Site where the training will occur:***

Name of Preceptor \_\_\_\_\_ Approval #NHAP \_\_\_\_\_

Name of Facility \_\_\_\_\_ Approval #NHAS \_\_\_\_\_

Facility Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

***If not no approved Preceptor or Training Site, applications to be submitted for:***

Name of Proposed Preceptor: \_\_\_\_\_ License # NHA \_\_\_\_\_

Name of Facility \_\_\_\_\_

Facility Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**WORK EXPERIENCE:** Note: Applicant must submit proof of experience with an "Affidavit of Experience" (pages 9 & 10 of this application). Applicant must complete Part I and request employer/supervisor to complete Part II

Name of Facility \_\_\_\_\_

Job title \_\_\_\_\_

Facility Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Management Experience: \_\_\_\_\_

Number of Employees Supervised: \_\_\_\_\_  
(Indicate the number supervised in the last 3-5 years)

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Name of Facility \_\_\_\_\_

Job title \_\_\_\_\_

Facility Address \_\_\_\_\_  
Street City State Zip

Duties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Management Experience: \_\_\_\_\_

Number of Employees Supervised: \_\_\_\_\_  
(Indicate the number supervised in the last 3-5 years)

**PROFESSIONAL BACKGROUND**

If you answer yes to any of the following questions, attach a Letter of Explanation, relevant documents and a certified copy(s) of any final disposition indicating a description of the current status. For the purpose of the following questions, the terms "licensee," "registration," and "certification" are synonymous.

Do you now hold, or have you in the past held another professional license? If "Yes" complete the following and attach additional sheets if necessary. **Yes** \_\_\_ **No** \_\_\_

License Title \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_

Have you had revoked or suspended or otherwise sanctioned any license issued to you by any board or agency in Georgia or any other state? **Yes** \_\_\_ **No** \_\_\_

Were you denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license or the privilege of taking an examination by any state licensing board? **Yes** \_\_\_ **No** \_\_\_

Have you knowingly failed to renew a license during an investigation of disciplinary action? **Yes** \_\_\_ **No** \_\_\_

Have you been subject to disciplinary action or had your membership revoked by a professional organization governing the practice of that profession? **Yes** \_\_\_ **No** \_\_\_

To the best of your knowledge, is there any disciplinary action pending against you by any licensing board or professional organization? **Yes** \_\_\_ **No** \_\_\_

Have you been arrested, charged or sentenced for the commission of a felony or any crime involving moral turpitude? **Yes** \_\_\_ **No** \_\_\_

Are you currently unable to practice with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, chemicals or any other type of material, or as a result of any mental or physical condition? **Yes** \_\_\_ **No** \_\_\_

Have you had any suit filed against you related to the practice of a profession?  
**Yes** \_\_\_ **No** \_\_\_

Have you ever had your Medicaid and /or Medicare privileges restricted or revoked?  
**Yes** \_\_\_ **No** \_\_\_

Have you ever been arrested or convicted of a felony, misdemeanor (other than a minor traffic violation), crime involving moral turpitude, or a crime violating federal or state law relating to controlled substances or dangerous drugs? (DWI and DUI are not minor traffic violations.) For purposes of this question, a "conviction" includes a finding of verdict of guilty, plea of guilty, a plea of nolo contendere, or first offender treatment, and also includes adjudication of guilt or sentence withheld or not entered on the charge (s). NOTE: The answer to this question is "YES" if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled & completed probation under First offender and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record.

**Yes** \_\_\_ **No** \_\_\_

If "yes," please include a certified copy of the court records and final disposition from the court with your application. In the event the file no longer exists, you must submit documentation from the court stating that fact. Also include a personal letter of explanation regarding each incident.

Georgia Board of Nursing Home Administrators \* Affidavit of Applicant

Please document with your initials that you have reviewed each of the resources listed below. Have the Affidavit notarized and return to the NHA Board, 237 Coliseum Drive, Macon, Georgia 31217-3858.

OFFICIAL CODE OF GEORGIA ANNOTATED (OCGA). All statutory requirements are accessible via: <http://www.lexisnexis.com/hottopics/gacode/Default.asp>

\_\_\_\_\_ Department of Community Health, Division of Medical Assistance, Part I Policies and Procedures; Part II Policies and Procedures Applicable to Nursing Facility Services (Chapter 600-1100 and Appendices)

\_\_\_\_\_ Georgia State Board of Nursing Home Administrators Law (OCGA 43-27-11)

\_\_\_\_\_ Georgia statutes regarding Living Will, Durable Power of Attorney for Health Care, Withholding or withdrawal of life-sustaining procedures (OCGA Section 31)

\_\_\_\_\_ Determination of residences of decedent in care of nursing home at time of death (OCGA 53-1-5)

\_\_\_\_\_ Fire Safety Codes (OCGA 25-2-13{d, e and f})

\_\_\_\_\_ OCGA Title 31 pertaining to Department of Human Resources with particular attention to sections pertaining to Long Term Care Facilities

DHS RULES pertaining to Nursing Homes (290) are accessible via: [http://rules.sos.state.ga.us/cgi-bin/page.cgi?g=DEPARTMENT\\_OF\\_HUMAN\\_SERVICES%2Findex.html&d=1](http://rules.sos.state.ga.us/cgi-bin/page.cgi?g=DEPARTMENT_OF_HUMAN_SERVICES%2Findex.html&d=1)

BOARD RULES pertaining to Nursing Home administrators (393) are accessible via: [www.sos.state.ga.us/plb/nursinghome](http://www.sos.state.ga.us/plb/nursinghome)

\_\_\_\_\_ Nursing Homes (Chapter 290-5-8)

\_\_\_\_\_ Long Term Care Facilities: Resident’s Bill of Rights (Chapter 290-5-39)

\_\_\_\_\_ Rules of Georgia State Board of Nursing Home Administrators (Chapter 393-1 to 393-13)

\_\_\_\_\_ Disaster Preparedness Plans (Chapter 290-5-45)

\_\_\_\_\_ Food Service (Chapter 290-5-14)

\_\_\_\_\_ (Date) \_\_\_\_\_ (PRINTED Name of Applicant) \_\_\_\_\_ (Signature of Applicant)

Sworn to and subscribed before me this

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,

Signature of Notary Public \_\_\_\_\_

My commission expires: \_\_\_\_\_ Notary Seal





**AFFIDAVIT OF EXPERIENCE – FORM A**

- Please type or print legibly
- Complete a form for each employer in order to meet the required experience for **your application**
- Applicant **completes Part I**
- Owner/Administrator of the nursing facility or the employer/superior in the chain of command at the home office that operates the licensed nursing facility and/or hospital **completes Part II**

**PART I – APPLICANT**

Applicant's Name: \_\_\_\_\_

Name of business/corporation that owns facility: \_\_\_\_\_

Name of facility \_\_\_\_\_

Address of facility \_\_\_\_\_  
Street City State Zip

Phone number of facility \_\_\_\_\_ Position held \_\_\_\_\_

Dates employed - From: \_\_\_\_\_ to: \_\_\_\_\_  
Month/Year Month/Year

Description of Responsibilities:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Affidavit**

I, the above Applicant, attest that the above information is a true and accurate representation of experience obtained in a nursing facility or home office that operates licensed nursing facilities or hospitals.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

**PART II – OWNER/ADMINISTRATOR/EMPLOYER/SUPERIOR**

**Instructions**

- Please review the applicant’s description of management experience
- Please submit comments or any additional information that will assist the Board in its decision regarding licensure for the applicant

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, the undersigned \_\_ Owner/Administrator of the nursing facility or \_\_ Employer or Superior in the chain of command at the home office that operates licensed nursing facilities and/or hospitals, attest that the description provided by the Applicant of the experience obtained in a nursing facility, home office of a business or corporation that operates licensed nursing facilities or hospitals, is true and accurate, and I further acknowledge that I may be required to furnish additional information promptly for this application to be processed.

\_\_\_\_\_ (Date)                      \_\_\_\_\_ (Signature of Nursing Home Administrator/Employer)

Subscribed and sworn to before me this

\_\_\_\_\_ Day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Public

My Commission Expires \_\_\_\_\_

*Notary Seal*

# Georgia Board of Nursing Home Administrators

237 Coliseum Drive, Macon, GA 31217 \* (478) 207-2440

## AIT PROGRAM OUTLINE - 500 HOUR

**\*\*Preceptor: Please indicate below your established plan for the AIT training.**

(Please print **clearly** or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Proposed AIT Beginning Date: \_\_\_\_\_ Proposed date of Completion: \_\_\_\_\_

**RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 200 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.*

NURSING	_____	SOCIAL SERVICES	_____
DIETARY	_____	RECREATION/VOLUNTEERS	_____
MEDICAL RECORDS	_____	REHABILITATION SERVICES	_____
MEDICAL/ALLIED HEALTH	_____	PHARMACEUTICAL PROGRAM	_____

**HUMAN RESOURCES: (A minimum of 80 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.*

ADMINISTRATION \_\_\_\_\_

**FINANCE: (A minimum of 65 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.*

BUSINESS \_\_\_\_\_

**PHYSICAL ENVIRONMENT: (A minimum of 40 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.*

HOUSEKEEPING/LAUNDRY \_\_\_\_\_ MAINTENANCE \_\_\_\_\_

**LEADERSHIP AND MANAGEMENT: (A minimum of 90 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.*

**OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_**

**TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_**

**TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:** I certify that the AIT whose signature appears below has agreed to complete this AIT program of **500** hours under my personal supervision.

\_\_\_\_\_  
(Signature of Preceptor)

GA NHA Preceptor # NHAP \_\_\_\_\_

GA NHA License # NHA \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)

# Georgia Board of Nursing Home Administrators

237 Coliseum Drive, Macon, GA 31217 \* (478) 207-2440

## AIT PROGRAM OUTLINE - 1000 HOUR

**\*\*Preceptor: Please indicate below your established plan for the AIT training.**

(Please print **clearly** or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Proposed AIT Beginning Date: \_\_\_\_\_ Proposed date of Completion: \_\_\_\_\_

**RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 320 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.*

NURSING \_\_\_\_\_ SOCIAL SERVICES \_\_\_\_\_

DIETARY \_\_\_\_\_ RECREATION/VOLUNTEERS \_\_\_\_\_

MEDICAL RECORDS \_\_\_\_\_ REHABILITATION SERVICES \_\_\_\_\_

MEDICAL/ALLIED HEALTH \_\_\_\_\_ PHARMACEUTICAL PROGRAM \_\_\_\_\_

**HUMAN RESOURCES: (A minimum of 150 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.*

ADMINISTRATION \_\_\_\_\_

**FINANCE: (A minimum of 150 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.*

BUSINESS \_\_\_\_\_

**PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 80 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.*

HOUSEKEEPING/LAUNDRY \_\_\_\_\_ MAINTENANCE \_\_\_\_\_

**LEADERSHIP AND MANAGEMENT: (A minimum of 200 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.*

**OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_**

**TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_**

**TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:** I certify that the AIT whose signature appears below has agreed to complete this AIT program of **1000** hours under my personal supervision.

\_\_\_\_\_  
(Signature of Preceptor)

GA NHA Preceptor # NHAP \_\_\_\_\_

GA NHA License # NHA \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)

**GEORGIA BOARD OF NURSING HOME ADMINISTRATORS**

237 Coliseum Drive, Macon, GA 31217 \* (478) 207-2440

**AIT PROGRAM OUTLINE - 1500 HOUR**

**\*\*Preceptor: Please indicate below your established plan for the AIT training.**

(Please print **clearly** or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Proposed AIT Beginning Date: \_\_\_\_\_ Proposed date of Completion: \_\_\_\_\_

**RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 530 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.*

NURSING	_____	SOCIAL SERVICES	_____
DIETARY	_____	RECREATION/VOLUNTEERS	_____
MEDICAL RECORDS	_____	REHABILITATION SERVICES	_____
MEDICAL/ALLIED HEALTH	_____	PHARMACEUTICAL PROGRAM	_____

**HUMAN RESOURCES: (A minimum of 200 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.*

ADMINISTRATION \_\_\_\_\_

**FINANCE: (A minimum of 200 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.*

BUSINESS \_\_\_\_\_

**PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 170 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.*

HOUSEKEEPING/LAUNDRY \_\_\_\_\_ MAINTENANCE \_\_\_\_\_

**LEADERSHIP AND MANAGEMENT: (A minimum of 300 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.*

**OTHER (Specify): \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_**

**TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_**

**TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:**

I certify that the AIT whose signature appears below has agreed to complete this AIT program of **1500** hours under my personal supervision.

\_\_\_\_\_  
(Signature of Preceptor)

GA NHA Preceptor # NHAP \_\_\_\_\_

GA NHA License # NHA \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)

# Georgia Board of Nursing Home Administrators

237 Coliseum Drive, Macon, GA 31217 \* (478) 207-2440

## AIT PROGRAM OUTLINE - 2000 HOUR

**\*\*Preceptor: Please indicate below your established plan for the AIT training.**

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF AIT Site WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Proposed AIT Beginning Date: \_\_\_\_\_ Proposed date of Completion: \_\_\_\_\_

**RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 750 hours) TOTAL HOURS \_\_\_\_\_**

Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

NURSING	_____	SOCIAL SERVICES	_____
DIETARY	_____	RECREATION/VOLUNTEERS	_____
MEDICAL RECORDS	_____	REHABILITATION SERVICES	_____
QUALITY IMPROVEMENT	_____	PHARMACEUTICAL PROGRAM	_____

**HUMAN RESOURCES: (A minimum of 250 hours) TOTAL HOURS \_\_\_\_\_**

Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

ADMINISTRATION \_\_\_\_\_

**FINANCE: (A minimum of 250 hours) TOTAL HOURS \_\_\_\_\_**

Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

BUSINESS \_\_\_\_\_

**PHYSICAL ENVIRONMENT: (A minimum of 250 hours) TOTAL HOURS \_\_\_\_\_**

Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

HOUSEKEEPING/LAUNDRY \_\_\_\_\_ MAINTENANCE \_\_\_\_\_

**LEADERSHIP AND MANAGEMENT: (A minimum of 400 hours) TOTAL HOURS \_\_\_\_\_**

Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

**OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_**

**TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_**

**TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:** I certify that the AIT whose signature appears below has agreed to complete this AIT program of 2000 hours under my personal supervision.

\_\_\_\_\_  
(Signature of Preceptor)

GA NHA Preceptor # NHAP \_\_\_\_\_

GA NHA License # NHA \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)