



PART II – PROFESSIONAL BACKGROUND

If you answer "Yes" to any of the following questions, **attach an explanation, relevant documents and a description of the current status.** For the purpose of the following questions, the terms "license," "registration," and "certification" are synonymous.

Yes  No Have you been approved in the past as a Preceptor? If "Yes", please explain [Site, Date/s, etc.]

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

License Title \_\_\_\_\_

State \_\_\_\_\_ Date Issued \_\_\_\_\_ Expiration Date \_\_\_\_\_

License Title \_\_\_\_\_

State \_\_\_\_\_ Date Issued \_\_\_\_\_ Expiration Date \_\_\_\_\_

Yes  No 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 revoked or restricted?

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.

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.

PART III - A.I.T. APPROVED SITE(S)

**AIT APPROVED SITE**

**NAME OF SITE WHERE YOU ARE THE NHA OF RECORD, AND WILL BE PRECEPTOR:**

NAME:

ADDRESS: \_\_\_\_\_  
Street City State Zip Code

PHONE: ( )

FAX: ( )

**AIT APPROVED SITE: Other facility where you were the approved preceptor**

NAME:

ADDRESS: \_\_\_\_\_  
Street City State Zip Code

PHONE: ( )

FAX: ( )

**AIT APPROVED SITE: Other facility where you were the approved preceptor**

NAME:

ADDRESS: \_\_\_\_\_  
Street City State Zip Code

PHONE: ( )

FAX: ( )

**AFFIDAVIT OF EXPERIENCE – FORM A**

- Please type or print legibly
- Complete a form for each employer in order to meet **the required nursing home** 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 facility or home office that operates the licensed nursing facility and/or hospital **completes Part II**

**PART I – APPLICANT**

Applicant’s Name \_\_\_\_\_

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

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

Address of facility \_\_\_\_\_

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**

- Please review the applicant’s description of **nursing home** experience.
- Please submit comments or any additional information that will assist the Board in its decision for approval of 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 above 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*



**DUTIES OF PRECEPTOR:**  
(PLEASE KEEP THIS SHEET FOR YOUR RECORDS)

**Board Rule: 393-4-.02** – The preceptor is solely responsible for ensuring that the AIT complies with the Laws and Rules of the Board, and must attest to such compliance upon completion of the AIT program.

The preceptor must ensure that the AIT is not over-burdened with routine responsibilities that may be detrimental to his or her training, and must ensure that the intern is afforded a broad and comprehensive experience.

A monthly report is to be submitted to the Board beginning 30 days from the starting date of the AIT program. This report must follow the individualized schedule and describe the activities of the calendar month and should be signed and notarized by both the Preceptor and the AIT. 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. DO NOT COMBINE MONTHS ON ONE FORM.

**Supervision Chart**

<b>Full Time or Part Time</b>									
<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>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. 500 Hours</td> <td style="width: 50%;">3 month approval</td> </tr> <tr> <td>2. 1000 Hours</td> <td>6 month approval</td> </tr> <tr> <td>3. 1500 Hours</td> <td>12 month approval</td> </tr> <tr> <td>4. 2000 Hours</td> <td>12 month approval</td> </tr> </table>	1. 500 Hours	3 month approval	2. 1000 Hours	6 month approval	3. 1500 Hours	12 month approval	4. 2000 Hours	12 month approval
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2. 1000 Hours	6 month approval								
3. 1500 Hours	12 month approval								
4. 2000 Hours	12 month approval								
<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>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. 500 Hours</td> <td style="width: 50%;">3 month approval</td> </tr> <tr> <td>2. 1000 Hours</td> <td>6 month approval</td> </tr> <tr> <td>3. 1500 Hours</td> <td>12 month approval</td> </tr> <tr> <td>4. 2000 Hours</td> <td>12 month approval</td> </tr> </table>	1. 500 Hours	3 month approval	2. 1000 Hours	6 month approval	3. 1500 Hours	12 month approval	4. 2000 Hours	12 month approval
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<p>An AIT License is issued 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 license expires. Approval of reports or extensions is at the Board's discretion.</p>	<p>The <b><u>AIT outline</u></b> form must be submitted for <b><u>each</u></b> individual you are supervising. This form should be submitted with the AIT application.</p>								

Please submit the “Certification of AIT Program Completion Form” to the Board with the final monthly report due. This form must be received by the Board. Once the AIT Program completion form is approved by the Board, the AIT will be required to submit an application for a Nursing Home Administrators license and the fee within thirty (30) days from the approval date of the completion report by the Board.

**Approval to register and sit for the exam will not be granted until the NHA application is received and approved.**

Please keep copies of all approval/denial letters from the Board. It is the responsibility of the preceptor and the AIT to keep track of the total hours approved by the Board.