



GEORGIA STATE BOARD OF NURSING HOME ADMINISTRATORS  
 237 Coliseum Drive  
 Macon, Georgia 31217-3858  
 (478) 207-2440 (Telephone)  
[www.sos.georgia.gov/plb/nursing\\_home](http://www.sos.georgia.gov/plb/nursing_home)

Application for **REINSTATEMENT** of Approval of an  
 Nursing Home Administrator In **TRAINING PROGRAM SITE**

- **DO NOT** SUBMIT THIS APPLICATION FOR INITIAL APPROVAL AS A NHA AIT TRAINING SITE, ONLY FOR THE **REINSTATEMENT** OF A LAPSED OR REVOKED NHA TRAINING SITE APPROVAL NUMBER
- Please print or type clearly. If space is not sufficient, attach additional sheets.
- Enclose NON-REFUNDABLE application Fee of **\$150.00**. Submit separate application and fee for each training site approval for reinstatement application.
- **Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.**
- An AIT Training Program may take place in multiple sites — different facilities all owned or managed by the same corporation or business entity. A corporation or business entity may designate its AIT training sites. Each facility must be approved by the Board. Please submit a separate application for each site proposed. See Board Rules Chapters 393-4-.01 and 393-4-.05.

**NOTE: For Reinstatement of Approval of a Lapsed or Revoked AIT Site, applicants must also submit:**

- This application;
- The application fee of \$150 (made payable to the GA Nursing Home Administrators Board);
- The name and license numbers of the NHA/Preceptor for the site applied for;
- Copies of all GA DCH facility compliance survey reports from Inspections, Plan of Corrections and Compliance letters for the last 18 months; and
- Must have 60 or more beds for approval (60 to 100 - 1 AIT; 101 or more 2 AIT's **MAX**).

**PART I - NURSING HOME FACILITY INFORMATION**

NAME OF NURSING HOME: \_\_\_\_\_ TRAINING SITE # \_\_\_\_\_  
 \_\_\_\_\_ NHAS \_\_\_\_\_

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

TELEPHONE: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

NAME OF ADMINISTRATOR: \_\_\_\_\_

NH Administrator License #: NHA \_\_\_\_\_ NHA Preceptor Approval #: NHAP \_\_\_\_\_

If no active NH Preceptor approval number, have you applied for Board approval to be a preceptor in this facility: \_\_\_ Yes \_\_\_ No

**NOTE:** *If there is no approved preceptor or an application pending for preceptor at this site, then the site cannot be approved by the Board until there is an approved NHAP.*

**OWNERSHIP:**

NAME/S OF OWNERS: \_\_\_\_\_  
 \_\_\_\_\_

**TYPE OF OWNERSHIP:**

\_\_\_ Individual \_\_\_ Proprietorship \_\_\_ Partnership \_\_\_ Corporation \_\_\_ Other: \_\_\_\_\_

**PART II –SINGLE OR MULTIPLE AIT PROGRAM SITE**

Is this proposed AIT program site:  
 \_\_\_ Yes \_\_\_ No A single site?

Yes  No One site which will be part of a multiple site program? If "yes", please list names of other sites and state whether they have been approved or if you are submitting a separate application and fee for their approval:

Name: \_\_\_\_\_

Approved:  Yes  No

Application Pending:  Yes  No

Name: \_\_\_\_\_

Approved:  Yes  No

Application Pending:  Yes  No

Name: \_\_\_\_\_

Approved:  Yes  No

Application Pending:  Yes  No

*(Add additional pages if needed)*

**PART III – QUALIFICATIONS FOR SITE OF AIT PROGRAM**

**NUMBER OF BEDS/ALLOWED INTERNS:** \_\_\_\_\_ 60 – 100 / 1 Intern \_\_\_\_\_ 101 or more / 2 Interns\*

\*NO more than 2 interns allowed for any one site of 101 beds or more – See Board rule 393-4-.02(3)(a-b)

**RECENT DCH SURVEYS:**

Yes  No I have attached all DCH Surveys, Plans of Correction and Compliance letters from the eighteen (18) months prior to the date of this application. If no, why? \_\_\_\_\_

**PRIOR APPROVAL:**

Yes  No Has this facility ever been approved by the Board as an AIT program training site in a different name, or issued a different training site number than is noted above on page 1?

If "Yes," provide : DATE: \_\_\_\_\_ NHAS # \_\_\_\_\_

**PRIOR DENIAL:**

Yes  No Has this facility, ever been denied approval by the Board as an AIT program training site in a different name, or issued a different training site number, than is noted above on page 1?

If "Yes," provide:

NURSING HOME NAME: \_\_\_\_\_

EXPLANATION FOR DENIAL: \_\_\_\_\_

**AFFILIATION:**

Yes  No Is this facility now, or to be in the future, affiliated with another facility for the purpose of approval as an AIT training program site?

If, "Yes," provide:

NURSING HOME NAME: \_\_\_\_\_

EXPLAIN: \_\_\_\_\_

**PART IV – SIGNATURE**

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Nursing Home Administrator

