



GEORGIA STATE BOARD OF NURSING HOME ADMINISTRATORS
 237 Coliseum Drive, Macon, Georgia 31217-3858
 (478) 207-2440 – Telephone * <http://sos.ga.gov/plb/nursinghome>

MONTHLY REPORT OF ADMINISTRATOR-IN-TRAINING PROGRAM

- This form is for **one calendar month only, regardless of the number of weeks being reported** - do not combine weeks/months on one form.
- Submit the Monthly report Form to the NHA Board the first of each month following the month being reported: Fax to 866-888-7127; e-mail to ExamBoards-healthcare@sos.state.ga.us, or mail to: GA NHA Board, 237 Coliseum Drive, Macon, GA 31217-3858
- The AIT and Preceptor must sign the report, and have their signatures notarized.
- Training hours reported in excess of forty (40) shall require the filing of a **Petition for Waiver or Variance** of the Board rules **BEFORE/PRIOR TO** the month the AIT/Preceptor **anticipate hours** to be accrued in excess of forty (40). Failure to file Petition may result in the hours in excess of forty (40) **NOT** being accepted/counted toward the AIT's training programs goal.

NAME OF AIT: _____ MONTH: _____ YEAR: 20____

NAME OF PRECEPTOR: _____ NH Administrator License #: NHA _____
 NH Preceptor License #: NHAP _____

FACILITY: _____
 TELEPHONE #: () _____ Training Site License # NHAS _____

ADDRESS OF FACILITY: _____
 Street City State Zip Code

RECORD OF TIME: Describe Activity/Area Covered. Use additional sheets, if necessary, and identify the AIT.

Week of:	
# of Hours:	
	Signature of Department Head Or Area Supervisor: _____ Date: _____

RECORD OF TIME: Describe Activity/Area Covered. Use additional sheets, if necessary, and identify the AIT.

Week of:	
# of Hours:	
	Signature of Department Head Or Area Supervisor: _____ Date: _____

RECORD OF TIME: Describe Activity/Area Covered. Use additional sheets, if necessary, and identify the AIT.

Week of:	
# of Hours:	
	Signature of Department Head Or Area Supervisor: _____ Date: _____

RECORD OF TIME: Describe Activity/Area Covered. Use additional sheets, if necessary, and identify the AIT.	
Week of:	
# of Hours:	
	Signature of Department Head Or Area Supervisor: _____ Date: _____

RECORD OF TIME: Describe Activity/Area Covered. Use additional sheets, if necessary, and identify the AIT.	
Week of:	
# of Hours:	
	Signature of Department Head Or Area Supervisor: _____ Date: _____

AFFIDAVITS OF ADMINISTRATOR-IN-TRAINING AND PRECEPTOR

ADMINISTRATOR-IN-TRAINING:

Under penalty of perjury, I hereby certify that this Report is a correct statement and the information was taken from the records of the above-named nursing home/facility, which are available for examination, upon request, by the Georgia State Board of Nursing Home Administrators or any of its personnel.

Date _____ Signature of Administrator-in-Training _____

PRECEPTOR:

Under penalty of perjury, I hereby certify that this Report is a correct statement and the information as indicted in the departments/areas listed was under my personal supervision in the practice of nursing home administration.

Date _____ Signature of Preceptor _____ NHA License # _____

NOTARY:

Sworn to and subscribed before me
this _____ day of _____, 20_____

Notary Public
My Commission Expires: _____

NOTARY SEAL