

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 ever held a Nursing Home Administrator's license in another state? If "Yes," complete the section below:

License Title _____ License # _____

State _____ Date Issued _____ Expiration Date _____

License Title _____ License # _____

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 ever been arrested?

Note: *The answer to this question is "Yes" if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled and 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 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 convicted of a felony or misdemeanor (other than a traffic violation), entered a plea of guilty or nolo contendere, or entered a plea under a first offender provision?

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

Please indicate the name of the facility (site) where you will be a preceptor in the first section below. Please indicate any other approved sites for which you have provided services as a preceptor.

***NOTE:** If the facility you are the NHA of Record is not already a Board approved training site, please be sure and submit the Application for AIT Training Site Approval.

***AIT SITE - NAME of SITE WHERE YOU ARE THE NHA of RECORD, and WILL SERVE as the PRECEPTOR:**

ADDRESS: _____
Street City State Zip Code

PHONE: () FAX: () *License #:NHAS _____

PRIOR AIT APPROVED SITE: Other facility where you were the licensed preceptor

NAME:

ADDRESS: _____
Street City State Zip Code

PHONE: () FAX: ()

PRIOR AIT APPROVED SITE: Other facility where you were the licensed preceptor

NAME:

ADDRESS: _____
Street City State Zip Code

PHONE: () FAX: ()

DUTIES OF PRECEPTOR:

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 the month after the starting date of the AIT program. If an AIT program begins in the middle of a month, then ONLY submit the first report for the days of the month training was completed – Do not overlap months in one report. This report must follow the individualized schedule and describe the activities of the 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.

Is there an individual who is already licensed, or will be applying for an AIT License to be trained at the site you are applying for with this application to be the Preceptor for? If so, please indicate:

NAME: _____

AIT License #: NHAT _____, or, application number (if already applied): _____

PART II – OWNER/ADMINISTRATOR/EMPLOYER/SUPERIOR

Instructions

- Please review the applicant’s description of experience;
- Please submit comments/additional information that will assist the Board in its decision.

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

APPLICANT SIGNATURE & AFFIDAVIT

YOU MUST SIGN THIS AFFIDAVIT IN THE PRESENCE OF A NOTARY

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia State Board of Long-Term Care Facility Administrators, and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) _____ I am a United States citizen 18 years of age or older. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or other document as indicated on (See list of acceptable documents on website).**

2) _____ I am **not** a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number**

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia State Board of Long-Term Care Facility Administrators and/or criminal prosecution.

Signature of Applicant

Date

Sworn to and subscribed before me this

_____ day of _____ 20_____

(Notary Seal)

Notary Public Signature

My Commission Expires: _____