



GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS
237 Coliseum Drive
Macon, Georgia 31217
404-424-9966
www.sos.ga.gov/plb

NURSING HOME ADMINISTRATOR IN TRAINING PROGRAM SITE APPLICATION

- Please print or type clearly. If space is not sufficient, attach additional sheets.
- Enclose Application Fee of **\$100.00 + 10.00 processing fee** per site. Submit separate application and fee for each NEW site.
- **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.

For approval as an AIT Site, the administrator must submit:

- This application;
- The application fee of \$100 + 10 processing fee (made payable to the Georgia State Board of Long-Term Care Facility Administrators);
- 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 beds - 1 AIT; 101 or more beds - 2 AIT's **MAX**).

PART I - NURSING HOME FACILITY INFORMATION

NAME OF NURSING HOME: _____

ADDRESS: _____
Street City State Zip Code

TELEPHONE: () _____ EMAIL: _____ FAX: () _____

NAME OF ADMINISTRATOR: _____

NH Administrator License #: NHA _____ NHA Preceptor License #NHAP _____

If no active NH Preceptor license 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:

NAMES 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 in the section provided below, 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 site?

If "Yes," provide : DATE: _____ NHAS # _____

PRIOR DENIAL:

Yes No Has this facility, ever been denied approval by the Board as an AIT program site?

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