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

APPLICATION FOR APPROVAL AS A NURSING HOME ADMINISTRATOR-IN-TRAINING (AIT)

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Nursing Home Administrators in the State of Georgia. Visit the website for information

The Board will not process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all required information and documentation is complete and correct. An incomplete application will result in delayed processing. Incomplete applications are void after one year and will result in a new application and fee. Please use the following checklist to ensure that you submit a COMPLETE application.

The **$225.00** application fee + **$10.00** processing fee is **NON-REFUNDABLE**; Make payable to the **Georgia State Board of Long-Term Care Facility Administrators.** Fee must be included with application. ***Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.***

SECURE & VERIFIABLE DOCUMENT & AFFIDAVIT OF CITIZENSHIP	Changes to Georgia Law (OCGA 50-36-1) provide that **all applicants for licensure MUST** provide a Secure & Verifiable Document and an Affidavit of Citizenship with their application. The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "not later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary. **ALL APPLICANTS FOR NH AIT APPROVAL MUST PROVIDE THIS DOCUMENTATION OR THE APPLICATION WILL NOT BE PROCESSED.**

- ☐ BACKGROUND INFORMATION: All questions must be answered. Any question answered "yes" requires further documentation to be submitted. Attach a letter of Explanation if you have had any arrests, criminal convictions, charges, or sanctions by another state licensing board. You must also submit a certified copy of the court's final disposition, or the official document indicating the current status of the sanction or disciplinary action(s). Approval of licensure is at the Board's discretion.

- ☐ EDUCATION: Submit an official copy of your college transcript or a copy of your High School Diploma. Official Transcripts only will be accepted, no student copies, and must indicate the degree awarded and date degree was conferred.

- ☐ AIT Applicants must indicate on this application a current Board approved Nursing Home Administrator Preceptor and Board approved Facility Training Site, OR, that applications have been/will be submitted for Board approval for a new Nursing Home Administrator Preceptor and a new Board approved Facility Training Site (or a Reinstatement application of a prior approval).

- ☐ PROGRAM OUTLINE FORM: The Preceptor of the AIT must complete and submit the applicable Program Outline Form with the AIT's application. If the Board approves a different length for the program, the Preceptor will be notified in writing so that a corrected outline can be submitted to the Board.

- ☐ In accordance with Board rule's 393-3-.02, the length of the AIT, Internship or work experience is defined according to the level of educational requirements that are met. **Only Board approved Georgia AIT Preceptor and Training Site programs are acceptable**.

- ☐ DOCUMENTATION COMPLETION FORM: Once the AIT program is complete, the Preceptor will submit to the Board the Certification of Completion form along with the final monthly report due from the AIT to the Board.

************* **NEW - VERY IMPORTANT – PLEASE READ CAREFULLY** **********

Upon completion of the AIT program, and the approval by the Board of the AIT Program Completion Report, the AIT shall within thirty (30) days of the Board's notification to the AIT of their approval of the training program completion submit an application and the required fee for licensure as a Nursing Home Administrator.
Once the AIT program completion report is received and approved by the Board, the AIT will be eligible to register and sit for the Exam:

National Association of Long Term Care Administrator Boards (NAB) EXAM: All AIT applicants must pass the NAB Nursing Home Administrators Licensing Examination to obtain licensure as a Georgia Nursing Home Administrator. Upon approval by the Board to register, the applicant must contact NAB for the purpose of registering to take the examination. Once the examination has been taken the Board is notified of the applicant's score.

If the exam is passed, then a license may be issued if all other licensure requirements are met. If the exam is failed, the examination can be retaken. In order to register to retake the examination, the applicant contacts NAB as previously instructed. For additional information regarding this exam, please go to www.nabweb.org.

Failure to take and pass the exam within six months of the date of approval by the Board of the NHA application for licensure shall require the submission of a new application and fee.

FOR BOARD USE ONLY
Amount Submitted ____________
Date ____________
Receipt # ____________

FOR BOARD USE ONLY
Certificate Number ____________
Date Issued ____________
Applicant No. ____________

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APPLICATION FOR APPROVAL AS A NURSING HOME ADMINISTRATOR-IN-TRAINING (AIT)

Application Fee $225.00 + $10.00 processing fee (non-refundable)
Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.

Method Obtained by - Application

PERSONAL INFORMATION

Name ____
Last First Middle

________-______-______________ _____/_____/______ Sex:_____Male_____Female
*Social Security Number Date of Birth

*This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A.1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes

Physical Address: ____
*(P.O. Box **not** acceptable)* Number and Street Apt. No City/State Zip

Mailing Address: ____
(If different/P.O. Box is acceptable) Number and Street Apt. No City/State Zip

____________________ ____________________ ____________________
Telephone Number Day Telephone Number Evening Cell Phone Number

E Mail Address: ____
(Please Print Clearly - Your e-mail address will not be shared with any other party)

EDUCATION

College/University Attended______________________________

Degree____________________Date Conferred________________

Name of High School______________________Graduation Date__________

SUPERVISION: *The AIT program may be Full Time or Part Time. Will you be in program on a full time basis (40 hours per week)____or part time basis (an average of 24 hours per week)? ___*

Supervision Chart

Full Time or Part Time	Check next to Length of Program Required
Full Time = 40 hours/wk 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.	1. 500 Hours ____3 month license 2. 1000 Hours ____6 month license 3. 1500 Hours ____12 month license 4. 2000 Hours ____12 month license
Part Time = 24 hours minimum/wk 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.	1. 500 Hours ____6 month license 2. 1000 Hours ____12 months license 3. 1500 Hours ____18 months license 4. 2000 Hours ____24 months license
An AIT approval is granted only for the length of program indicated above. Written request for an extension must be submitted at least 30 days before approval expires. Approval of reports or extensions is at the Board's discretion.	**NOTE**: 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.

Applicant must indicate a current Board approved Preceptor and a current Board approved Training Site where the training will occur:

Name of Preceptor________________________________Approval #NHAP_________

Name of Facility ________________________________ Approval #NHAS__________

Facility Address____

____
Street City State Zip

*If you **do not** have a Board approved Preceptor or Training Site for the training program, applications must be submitted by a facility NHA of record. Please indicate below who the NHA of record is and the facility that will be submitting their application for preceptor and training site approval:*

Name of Proposed Preceptor: ____________________________ License # NHA________

Name of Facility____

Facility Address____
Street City State Zip

APPLICANTS WORK EXPERIENCE: Note: An applicant for AIT approval must submit proof of experience with an "Affidavit of Experience" (pages 9 & 10 of this application). Applicant must complete Part I and request employer/supervisor to complete Part II

Name of Facility____

Job title____

Facility Address____
Street City State Zip

Duties: ____

____

____

____

Management Experience: ____

Number of Employees Supervised: _____________
(Indicate the number supervised in the last 3-5 years)

****

Name of Facility____

Job title____

Facility Address____
Street City State Zip

Duties:____

____

____

____

Management Experience: ____

Number of Employees Supervised: _____________
(Indicate the number supervised in the last 3-5 years)

PROFESSIONAL BACKGROUND

If you answer yes to any of the following questions, attach a Letter of Explanation, relevant documents and a certified copy(s) of any final disposition indicating a description of the current status. For the purpose of the following questions, the terms "licensee," "registration," and "certification" are synonymous.

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

License Title______________State_________Expiration Date__________________

License Title______________State_________Expiration Date__________________

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 ____

Have you been subject to disciplinary action or been terminated by an employer while employed in any profession you are or have ever been licensed in?

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 & 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 ____

IMPORTANT: *If you checked "yes" to the above question, 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. In addition you **must** print out the "Background Investigation Consent" form found on the same webpage as this application. Failure to submit this consent form with application may result in delayed processing of the application.*

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 restricted or revoked?
Yes ___ No ____

Georgia State Board of Long-Term Care Facility Administrators
Affidavit of Applicant

Please document with your initials that you have reviewed each of the resources listed below and have the affidavit notarized.

All statutory requirements are accessible via: http://www.lexisnexis.com/hottopics/gacode/Default.asp
All Rules and Regulations are accessible via: http://rules.sos.ga.gov/

____ Department of Community Health, Division of Medical Assistance, Nursing Facility Services Policy Manual - from https://www.mmis.georgia.gov/portal/default.aspx select "Provider Manuals" under the "Provider Information" tab.

_____ Georgia State Board of Long-Term Care Facility Administrators Law (OCGA §43-27)

_____ Georgia statutes regarding Living Will, Durable Power of Attorney for Health Care, Withholding or withdrawal of life-sustaining procedures (OCGA § 31)

_____ Georgia statutes pertaining to Department of Community Health with particular attention to sections pertaining to Long Term Care Facilities (OCGA § 31)

_____ Fire Safety Codes (OCGA § 25-2-13)

_____ Disaster Preparedness Plans (Chapter 111-8-16)

_____ DHS Rules pertaining to Nursing Homes/Long-Term Care Facilities (290).

_____ Board Rules pertaining to Long-Term Care Facility Administrators (393).

____________	______________________________	______________________________
(Date)	(PRINTED Name of Applicant)	(Signature of Applicant)

Sworn to and subscribed before me this

____day of _____________, 20_____

Signature of Notary Public___________________________________

My commission expires: ______________ *Notary Seal*

AFFIDAVIT OF CITIZENSHIP

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: __________________________

Georgia State Board of Long-Term Care Facility Administrators
237 Coliseum Drive, Macon, Georgia 31217-3858
Phone: 404-424-9966 * www.sos.ga.gov

AFFIDAVIT OF EXPERIENCE – FORM A

•Please type or print legibly

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

PART I – APPLICANT

Applicant's Name: ____

Name of business/corporation that owns facility: ____________________________________

Name of facility____

Address of facility____
Street City State Zip

Phone number of facility________________________ Position held____________________

Dates employed - From:___________________to: ______________________
Month/Year Month/Year

Description of Responsibilities:

____

____

____

____

____

____

____

Affidavit of Applicant

I, the above named 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

Instructions

- **Please review the applicant's description of management experience.**
- **Please submit comments or any additional information that will assist the Board in its decision regarding licensure for the applicant.**

Comments____

____

____

____

____

____

____

____

I, the undersigned ___ Owner/Administrator of the nursing home 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 Printed Name of Nursing Home Administrator/Employer

____

Signature of Nursing Home Administrator/Employer

Subscribed and sworn to before me this

_______ day of________________20_________

____

Notary Public

My Commission Expires_______________ *Notary Seal*

Georgia State Board of Long-Term Care Facility Administrators

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AIT PROGRAM OUTLINE - 500 HOUR

****Preceptor: Please indicate below your established plan for the AIT training.**

(Please print **clearly** or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: ____________________ Date ____________
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: ____________________

ADDRESS: ____________________

TELEPHONE: ____________ FAX: ____________

Proposed AIT Beginning Date: ____________ Proposed date of Completion: ____________

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 200 hours) TOTAL HOURS ________

Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

NURSING ________ SOCIAL SERVICES ________

DIETARY ________ RECREATION/VOLUNTEERS ________

MEDICAL RECORDS ________ REHABILITATION SERVICES ________

MEDICAL/ALLIED HEALTH ________ PHARMACEUTICAL PROGRAM ________

HUMAN RESOURCES: (A minimum of 80 hours) TOTAL HOURS ________

Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

ADMINISTRATION ________

FINANCE: (A minimum of 65 hours) TOTAL HOURS ________

Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

BUSINESS ________

PHYSICAL ENVIRONMENT: (A minimum of 40 hours) TOTAL HOURS ________

Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

HOUSEKEEPING/LAUNDRY ________ MAINTENANCE ________

LEADERSHIP AND MANAGEMENT: (A minimum of 90 hours) TOTAL HOURS ________

Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

OTHER: ____________________ **TOTAL HOURS** ________

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM ________

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR: I certify that the AIT whose signature appears below has agreed to complete this AIT program of **500** hours under my personal supervision.

____
(Signature of Preceptor)

GA NHA Preceptor # NHAP____________

GA NHA License # NHA____________

____
(Signature of AIT)

Georgia State Board of Long-Term Care Facility Administrators

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AIT PROGRAM OUTLINE - 1000 HOUR

****Preceptor: Please indicate below your established plan for the AIT training.**

(Please print **clearly** or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: ______________________________ Date ____________
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: ____________________

ADDRESS: ______________________________

TELEPHONE: ______________ FAX: ______________

Proposed AIT Beginning Date: ____________ Proposed date of Completion: ____________

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 320 hours) TOTAL HOURS ________

Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

NURSING	________	SOCIAL SERVICES	________
DIETARY	________	RECREATION/VOLUNTEERS	________
MEDICAL RECORDS	________	REHABILITATION SERVICES	________
MEDICAL/ALLIED HEALTH	________	PHARMACEUTICAL PROGRAM	________

HUMAN RESOURCES: (A minimum of 150 hours) TOTAL HOURS ________

Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

ADMINISTRATION ________

FINANCE: (A minimum of 150 hours) TOTAL HOURS ________

Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

BUSINESS ________

PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 80 hours) TOTAL HOURS _

Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

HOUSEKEEPING/LAUNDRY ________ MAINTENANCE ________

LEADERSHIP AND MANAGEMENT: (A minimum of 200 hours) TOTAL HOURS ________

Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

OTHER: ______________________________ **TOTAL HOURS** ________

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM ________________

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR: I certify that the AIT whose signature appears below has agreed to complete this AIT program of **1000** hours under my personal supervision.

____
(Signature of Preceptor)

GA NHA Preceptor # NHAP____________

GA NHA License # NHA____________

____
(Signature of AIT)

Georgia State Board of Long-Term Care Facility Administrators

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AIT PROGRAM OUTLINE - 1500 HOUR

****Preceptor: Please indicate below your established plan for the AIT training.**

(Please print **clearly** or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: ____ Date ____________________
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: ______________________________________

ADDRESS: ____

TELEPHONE: ___________________________ FAX: _________________________________

Proposed AIT Beginning Date: ________________ Proposed date of Completion: ______________________

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 530 hours) TOTAL HOURS __________

Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

NURSING	_____________	SOCIAL SERVICES	_____________
DIETARY	_____________	RECREATION/VOLUNTEERS	_____________
MEDICAL RECORDS	_____________	REHABILITATION SERVICES	_____________
MEDICAL/ALLIED HEALTH	_____________	PHARMACEUTICAL PROGRAM	_____________

HUMAN RESOURCES: (A minimum of 200 hours) TOTAL HOURS ____________

Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

ADMINISTRATION _____________

FINANCE: (A minimum of 200 hours) TOTAL HOURS ________________

Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

BUSINESS _____________

PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 170 hours) TOTAL HOURS _____

Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

HOUSEKEEPING/LAUNDRY _____________ MAINTENANCE _____________

LEADERSHIP AND MANAGEMENT: (A minimum of 300 hours) TOTAL HOURS ___________

Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

OTHER (Specify): ____ TOTAL HOURS ______

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM ________________________

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:

I certify that the AIT whose signature appears below has agreed to complete this AIT program of **1500** hours under my personal supervision.

____
(Signature of Preceptor)

GA NHA Preceptor # NHAP_________________

GA NHA License # NHA_____________

____
(Signature of AIT)

Georgia State Board of Long-Term Care Facility Administrators

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AIT PROGRAM OUTLINE - 2000 HOUR

****Preceptor: Please indicate below your established plan for the AIT training.**

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: ______________________________ Date ____________

(Title) (Last) (First) (Middle)

NAME OF AIT Site WHERE TRAINING IS TAKING PLACE: ______________________________

ADDRESS: ______________________________

TELEPHONE: ____________________ FAX: ____________________

Proposed AIT Beginning Date: ____________ Proposed date of Completion: ____________

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 750 hours) TOTAL HOURS ________

Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

NURSING ________ SOCIAL SERVICES ________

DIETARY ________ RECREATION/VOLUNTEERS ________

MEDICAL RECORDS ________ REHABILITATION SERVICES ________

QUALITY IMPROVEMENT ________ PHARMACEUTICAL PROGRAM ________

HUMAN RESOURCES: (A minimum of 250 hours) TOTAL HOURS ____________

Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

ADMINISTRATION ____________

FINANCE: (A minimum of 250 hours) TOTAL HOURS____________

Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

BUSINESS ____________

PHYSICAL ENVIRONMENT: (A minimum of 250 hours) TOTAL HOURS ________

Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

HOUSEKEEPING/LAUNDRY ________ MAINTENANCE ________

LEADERSHIP AND MANAGEMENT: (A minimum of 400 hours) TOTAL HOURS ________

Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

OTHER: ______________________________ **TOTAL HOURS** ____________

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM ____________

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR: I certify that the AIT whose signature appears below has agreed to complete this AIT program of **2000** hours under my personal supervision.

____
(Signature of Preceptor)

GA NHA Preceptor # NHAP____________

GA NHA License # NHA____________

____
(Signature of AIT)