GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS
237 Coliseum Drive
Macon, Georgia 31217-3858
404-424-9966 (Telephone)
www.sos.ga.gov/plb

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 + $10.00** processing fee (made payable to the Georgia State Board of Long-Term Care Facility Administrators)**.** 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-.01and 393-4-.05.

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

- 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 to100 - 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

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. **You MUST submit a copy of your Secure and Verifiable Document(s) such as driver's license, passport, or other document as indicated the listing on the website www.sos.ga.gov/plb.**

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. **You MUST 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 (See listing on the website www.sos.ga.gov/plb).**

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: __________________________