GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS
3920 Arkwright Rd. Suite 195
Macon, GA 31210
404-424-9966 (Telephone)
www.sos.ga.gov

DOCUMENTATION OF COMPLETION OF ADMINISTRATOR-IN-TRAINING PROGRAM – 1000 Hour

PART I - TO BE COMPLETED BY APPLICANT (ADMINISTRATOR-IN-TRAINING)

NAME: _____
Last First Middle Maiden

HOME ADDRESS: _____
Street Address City State Zip Code

PART II - TO BE COMPLETED BY PRECEPTOR

NAME: _____
First Last Middle Maiden

EXACT NAME(S) OF NURSING HOME(S):

1.

2.

3.

LOCATION(S) WHERE AIT PROGRAM WAS SERVED:

1. _____
Street Address City State Zip Code

2. _____
Street Address City State Zip Code

3. _____
Street Address City State Zip Code

DATE(S) OF AIT PROGRAM:	FROM:	TO:

PART III - PRECEPTOR'S EVALUATION OF APPLICANT'S ABILITY

INSTRUCTIONS:

- Please evaluate the above-named Administrator-in-Training's present ability to function in a Nursing Home. See Board Rule Chapter 393-4-.02(2).
- Use a separate sheet, as necessary, and identify the AIT.

PRECEPTOR'S EVALUATION:

❒Yes ❒ No Do you recommend that the Applicant's period as an administrator-in-training be approved by the Board as meeting the requirements for licensure? If "No," please explain and attach relevant documentation.

PART IV - SIGNATURES

APPLICANT:

By my signature below, I affirm that I have discussed this report with the Preceptor of my Administrator-in-Training Program.

_____ _____
Date Signature of Applicant

PRECEPTOR:

By my signature below, I affirm that I have discussed this report with the above-named Applicant for licensure as a Nursing Home Administrator.

_____ _____
Date Signature of Preceptor

Sworn to and subscribed before me this

_____ day of _____, 20____.

_____
Notary Public
My Commission Expires_____ **NOTARY SEAL**

Georgia State Board of Long-Term Care Facility Administrators
3920 Arkwright Rd. Suite 195, Macon, GA 31210 • 404-424-9966

CERTIFICATION OF PROGRAM COMPLETION – 1000 HOUR PROGRAM

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

NAME: _____ Date _____
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

DATE PROGRAM BEGAN: _____ DATE PROGRAM COMPLETED: _____

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.

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.

FINANCE: (A minimum of 150 hours) TOTAL HOURS _____
Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

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.

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/PRECEPTOR:
I certify that the AIT whose signature appears below has satisfactorily completed this AIT program of **1000** hours as outlined above under my personal supervision.

Provide **a narrative evaluation** of suitability for licensure as a nursing home administrator and **attach**.

_____ _____
(Signature of AIT) (Signature of Preceptor)

GA NHA License # NHA_____

Sworn to and subscribed before me this GA NHA Preceptor # NHAP_____

____day of _____, 20___,

Signature of Notary Public_____

My commission expires_____ ***Notary Seal***