



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](http://www.sos.ga.gov)

**DOCUMENTATION OF COMPLETION OF ADMINISTRATOR-IN-TRAINING PROGRAM – 500 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 – 500 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 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.*

**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.*

**FINANCE: (A minimum of 65 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 40 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 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/PRECEPTOR:**

I certify that the AIT whose signature appears below has satisfactorily completed this AIT program of **500** 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 \_\_\_\_\_

GA NHA Preceptor # NHAP \_\_\_\_\_

**Sworn to and subscribed before me this**

**\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_,**

Signature of Notary Public \_\_\_\_\_

My commission expires \_\_\_\_\_

*Notary Seal*