

GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS
237 Coliseum Drive, Macon, GA 31217 • 404-424-9966

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 _____
QUALITY IMPROVEMENT PRACTICE _____	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: (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 AIT)

(Signature of Preceptor)
GA NHA License # NHA _____
GA NHA Preceptor # NHAP _____