TENNESSEE BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS
665 MAINSTREAM DRIVE, 2nd Floor
NASHVILLE, TN 37243
LOCAL (615) 741-3807
TOLL FREE 1-800-778-4123 ext.7413807
http://tn.gov/health/topic/NHA-board

APPLICATION FOR LICENSE AS A NURSING HOME ADMINISTRATOR

INSTRUCTIONS

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board. If the application is not complete upon receipt by the Board's Administrative Office, a deficiency letter will be sent to you by certified mail or by email. The supporting documentation requested in the letter must be received in the Board's Administrative Office within forty five (45) days from the date of the initial deficiency letter. Files not completed within forty five (45) days will be closed.

1. Complete all pages of this application and enclose a non-refundable check for $460.00 payable to the Board of Examiners for Nursing Home Administrators. Please type or print legibly.

2. The Board may issue a temporary permit to participate in an Administrator-in-Training (AIT) program to applicants who have successfully completed the required academic preparation in an accredited school. The Board will not approve an individual for an A.I.T. program unless the individual is eligible to receive Board approval to take the National Association of Boards of Examiners for Long Term Care Administrators (NAB) examination upon completion of the A.I.T. program. A temporary permit for the AIT program shall cover a period of, at least, six (6) months. If you are eligible for a limited permit, please complete the attached "Administrator-in-Training" forms. These forms must be signed by your preceptor and notarized. Also, the attached Administrator-in-Training "Progress Report" and "Final Evaluation Report" forms must be completed by your preceptor and submitted to the board at designated periods.

3. The Board may issue a license to practice as a Nursing Home Administrator to an applicant who qualifies under any of the six (6) categories for licensure which are listed in the board rules. The board rules are online at http://share.tn.gov/sos/rules/1020/1020-01.20160907.pdf .

4. Attach a recent 'passport' style photograph of yourself taken within the last 12 months.

5. Attach two (2) original letters of reference attesting to your good moral character on the signator's professional letterhead. Photocopies are not accepted.

6. All applicants must complete, sign and have notarized the Declaration of Citizenship form and attach the documents required by the Declaration of Citizenship. The Declaration is online at http://tn.gov/assets/entities/health/attachments/PH-4183.pdf and must be attached to this application before submission. Attach proof of U.S. or Canadian citizenship or evidence of being legally entitled to live and work in the U.S. (e.g. copy of birth certificate, naturalization papers, or current visa status.) If not a U.S. or Canadian citizen, the front and back of the passport, valid visa, I-94 and Form I-766 must be submitted.

7. Request that official transcript be sent directly to the board administrative office from the educational institution where the degree was awarded. Include a copy of proof of graduation from high school or its equivalent.

8. Attach a copy of a resume of your employment within the last five (5) years.

9. A criminal background check is required. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions .

10. Complete and submit the Practitioner Profile Questionnaire which is online and will be available for you to complete online once this application is submitted. You are required by law to update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action. . For instructions, go to (http://tn.gov/assets/entities/health/attachments/PH-3585.pdf)

11. If you are or have ever been licensed, certified, registered, or permitted by any state to practice in any other health care profession, you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s).

12. All applicants for licensure must first receive Board approval to take the National Board examination and must successfully complete the examination within one (1) year from when Board approval to take the examination was granted. Successful completion of the examination is required before licensure is granted.

13. All applicants for licensure must successfully complete the Board's jurisprudence examination as a prerequisite to licensure. The examination must be completed and returned to the Board Administrative Office before the expiration of ninety (90) days from the date of notification of eligibility, or the applicant shall forfeit such eligibility and must begin the licensure process over.

INSTRUCTIONS FOR APPLICANTS BY RECIPROCITY

The Board may issue a license to practice as a Nursing Home Administrator by reciprocity to applicants who possess an active license to practice as a Nursing Home Administrator in another State and can demonstrate to the Board's satisfaction, successful completion of requirements that are substantially equivalent to or exceed the requirements for certification by the American College Health Care Administrators. Additional qualifications for applicants for a Nursing Home Administrator's license by reciprocity can be found in the board rules, a link to which can be located here - http://share.tn.gov/sos/rules/1020/1020-01.20160907.pdf .

1. **In addition to the above**, all applicants for licensure by reciprocity must request to have proof of successful completion of the National Board examination (NAB) submitted to the Board's administrative office directly from NAB or the other State of licensure. Successful completion of the examination is required before licensure is granted.

2. The Board has requested that all reciprocity applicants must also request employer (s) verification letter (s) of the last three (3) years.

3. The Board may consider for licensure an individual working for a minimum of five (5) of the last seven (7) years as a licensed nursing home administrator in another state in lieu of a degree and/or in lieu of an A.I.T. program.

INSTRUCTIONS FOR EDUCATION AND/OR EXPERIENCE REQUIREMENT

Please indicate which educational and/or experience requirement you have completed for licensure in Tennessee or the requirement you completed to receive a nursing home administrator's license in another state.

(___) 1. Baccalaureate, masters or doctorate degree in the area of health care administration from an accredited college or university with four hundred (400) hour Internship taken for credit and served in a licensed long term care nursing facility.

(___) 2. Baccalaureate, masters or doctorate degree from an accredited college combined with a Board- approved Administrator-In-Training program of at least six (6) months.

(___) 3. Associate degree and five (5) years of acceptable management experience as defined in rule 1020-1-.07 (1), combined with a Board approved Administrator-In-Training program of least six (6) months. To review the acceptable management experience rule, please visit: http://www.state.tn.us/sos/rules/1020/1020-01.20130313.pdf.

(___) 4. Combination of education and acceptable management experience as a hospital administrator and/or assistant or associate/hospital administrator. Applicant must have spent a minimum of five (5) of the last seven (7) years in full time hospital administration as either the chief executive officer or chief operating officer of a licensed hospital, and also obtained a baccalaureate, masters or doctorate degree from an accredited college with a four hundred (400) Board-approved Administrator-In-Training program completed in no less than three (3) months and no more than six (6) months combined.

(___) 5. Licensure by reciprocity.

If you checked # 1, complete pages 1 through 5 and have your college or university send a sealed transcript directly to the Board office. Enclose a resume for at least five (5) years; listing last employment first, including proof internship was completed in a long term care facility. Please indicate on your resume the name of the facility and the beginning and ending dates of where you completed your internship.

If you checked # 2, complete pages 1 through 5, have your preceptor complete pages 7 and 8, and have him/her retain pages 9 and 10 for filing additional reports to the Board. Have your college or university send a sealed transcript directly to the Board office. Enclose a Resume for at least five (5) years, listing last employment first.

If you checked # 3, complete pages 1 through 5, have your preceptor complete pages 7 and 8, and have him/her retain pages 9 and 10 for filing additional reports to the Board. Have your college or university send a sealed transcript directly to the Board office. Enclose a resume for at least the last five (5) years, listing last employment first.

If you checked # 4, complete pages 1 through 5, have your preceptor complete pages 7 and 8, and have him/her retain pages 9 and 10 for filing additional reports to the Board. Have your college or university send a sealed transcript directly to the Board's office. Enclose a resume for at least the last five (5) years, listing last employment first.

If you checked # 5, complete pages 1 through 6. You should also indicate your method of satisfying the Board's educational and/or experience requirements on page 2 of the application.

PLACE
FULL FACE,
PASSPORT STYLE
PHOTOGRAPH
HERE

2514) 001 - $450.00
2514) 006 - $ 10.00
$460.00

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PERSONAL INFORMATION

Name: ____
Last First Middle Maiden (if not used as your middle name)

Social Security Number*: ______________________ U.S. Citizen: Yes ____ No____
All applicants must complete the Declaration of Citizenship form

Date of Birth: ___________________________________ Entitled to Live and Work in the U.S. Yes ____ No___

Mailing Address: ____

____ Zip ________________________

Practice Address: ____

____

____ Zip ________________________

E-mail address: ____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. _____Yes _____ No

Race: ____ Phone: Home: ______________________________

Gender: Female _____ Male _____ Office: ______________________________

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ____ No___

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes ____ No ___

Have you ever been known by any other names besides what is listed above? Yes ____ No _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:_______

____

***You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code Ann. §36-5-1301(a), as authorized by 42 U.S.C. §405 (c) (2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that the Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.**

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for your attendance in college. Please include your post-graduate training. Use the back of this page if you need additional space. Request that transcripts be sent directly to the Board's Office from your school.

From: ________ ________ ______________________________ ____
MM/DD/YY MM/DD/YY Educational Institution Location

From: ________ ________ ______________________________ ____
MM/DD/YY MM/DD/YY Educational Institution Location

From: ________ ________ ______________________________ ____
MM/DD/YY MM/DD/YY Educational Institution Location

How many hours of supervised internship taken for credit in a licensed long term care nursing home facility have you obtained? ____

Do you have a baccalaureate, masters or doctorate degree in the area of health care administration from an accredited college or university with a four hundred (400) hour internship taken for credit and served in a licensed long term care nursing facility? Yes______ No______

Do you have a baccalaureate, masters or doctorate degree from an accredited college combined with a board-approved Administrator-In-Training (AIT) program of at least six (6) months? Yes______ No_______

Do you have any associate degree and five (5) years of acceptable management experience as defined in Rule 1020-01-.07(1), combined with a Board approved Administrator-In-Training (AIT) program of at least six (6) months? Yes______ No_______

Do you have a combination of education and acceptable management experience as a hospital administrator and/or assistant or associate hospital administrator for a minimum of five (5) out of the last seven (7) years in full time hospital administration as either the chief executive officer or chief operating officer of a licensed hospital and have obtained a baccalaureate, masters or doctorate degree from an accredited college with a four hundred (400) hour board approved AIT program? Yes____ No____

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	Supervisor	Address: (City, and State)	Position:	Duties:	Dates From: Mo./Yr. To: Mo./Yr.

	YES	NO
1. Have you ever failed any licensure examination?	____	____
If yes, which exam was taken and how many times have you failed? ____________________________________		
2. Have you ever previously applied for a nursing home administrator license in Tennessee?	____	____

CERTIFICATION INFORMATION

	YES	NO
Are you or have you ever been licensed in this profession in another state?	____	____
Are you or have you ever been licensed in any other profession in Tennessee or another state?	____	____

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE <u>EVER BEEN</u> OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED**. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	CURRENT STATUS

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. "**Ability to practice your profession**" is to be construed to include all of the following:
   a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments in your profession;
   b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.

		YES	NO
1.	Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice	___	___

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.

		YES	NO
2.	Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	___	___
	If so, please list: ____		
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	___	___
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	___	___
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	___	___
6.	Have you ever held or applied for a license, privilege, registration or certificate to practice your profession in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	___	___
9.	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	___	___
10.	Have you ever been rejected or censured by a professional association or society?	___	___
11.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you;	___	___
	b. Have you ever entered into any settlement of any legal action; or	___	___
	c. Are there any legal actions pending against you or to which you are a party?	___	___
12.	Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	___	___
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	___	___

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT

AFFIDAVIT AND RELEASE

I, ____, of ______________________________,
(Applicant's Name) *(City)* *(State)*

being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice in my profession.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

____ ______________________________
SIGNATURE **DATE**

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243
LOCAL (615) 741-3807
TOLL FREE 1-800-778-4123 ext. 7413807

TENNESSEE BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS

Please complete the top portion and mail this form to the regulatory board in each state where you hold or have held a license to practice as a Nursing Home Administrator. (If additional forms are required, this form may be duplicated.) Please disregard this page if you are not licensed or have never been licensed as a nursing home administrator in another state.

NOTE: Some states require a fee for providing verification information. In order to expedite your application, please contact the applicable state(s) inquire about required fees.

****

I was granted ____________________________ on ____________________________ by the State of ____________________________________
(License #) (Date)

The Tennessee Board of Examiners for Nursing Home Administrators requests that I submit evidence that my License in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Examiners for Nursing Home Administrators.

Date: ______________________________ Signature: ____

SSN#: _____________________________ Printed Name: ____

****

THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD

License Number: _______________________ Date Issued: ____________________________________

Basis of Issuance: Endorsement/Reciprocity With: ____
(Provide Description of Exam)

Written Examination: NAB _________ PES __________ OTHER ________ DATE _______________

Raw Score ____________________________ Scale Score ____________________________

Was an A.I.T./Practicum successfully completed: ____________________ Length of A.I.T./Practicum ______________

License currently registered: ________ Yes ________ No

Derogatory Information on File: ________ Yes ________ No
If "yes" please attach explanation.

____
Authorized Signature

____ State Seal
Title

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Nationwide (Toll Free) 1-800-778-4123 ext. 7413807

APPLICATION FOR ADMINISTRATOR-IN-TRAINING

Name: ____

Facility Name & Address: ____

____
Street City State Zip

____ ( )
County Telephone

I have entered into an agreement with ________________________ License #: ________________________
to serve as my preceptor during the period approved by the Board.

I hereby agree to hold the Tennessee Board of Examiners for Nursing Home Administrators, its members, officers, staff and examiners free from any damage or complaint by reason of any action they, or any of them, may take in connection with this application.

I understand that my A.I.T. program may not begin until notification of approval of my application by the Board.

I further understand that approval of my A.I.T. application does not imply approval to take the Nursing Home Administrators License Examination. Approval of qualifications to take the examination will be made after I complete my A.I.T. program.

I am also aware that I shall be assigned responsibilities in departmental rotation eight consecutive hours daily (except for regular days off), with a minimum of forty hours per week unless alternate arrangements are made with the Board in writing.

I further agree that I shall have no other "full or part time" work assignments in the facility during training hours, or any outside employment, unless such employment is known to and approved in writing by the Board and the preceptor prior to the start of my A.I.T. program.

By voluntarily entering into the A.I.T. program in an effort to become licensed as a Nursing Home Administrator, you are giving your permission to your Preceptor to evaluate your performance as regarding your qualifications as an administrator. You should consult your attorney concerning any legal relationship or right as between you and your Preceptor.

I will submit the most recent survey of the facility in which I will complete my A.I.T. program.

APPLICANT'S SIGNATURE IN FULL ____

Subscribed and sworn before me this ____________ day of ________________________, ____________.

My Commission Expires: ________________________

(SEAL)

____
Notary Public

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PRECEPTOR AND ADMINISTRATOR-IN-TRAINING APPLICATION FOR TRAINING FACILITY

The primary training of an Administrator-In-Training will take place in the Nursing Home of which the Preceptor is Administrator.

Name of Nursing Home: ____

Address: ______________________________________ Telephone: (____) __________________
Street Number and Name

____
City State Zip

Attach a copy of the latest licensure survey and the plan of correction for any deficiencies.

The facility must have an organizational structure with clearly defined and staffed departments, each with a designated department head. Except for administration, the designated department head may not be the administrator.

DEPARTMENT	NAME OF DEPARTMENT HEAD
Administration:	______________________
Nursing:	______________________
Dietary:	______________________
Social Services and Activities:	______________________
Medical Records:	______________________
Housekeeping, Maintenance, Laundry:	______________________
Number of Beds:	______________

AUTHORIZE I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

I, ______________________________, the Administrator of Home, hereby make application to the Tennessee State Board of Examiners for Nursing Home Administrators for approval of this Nursing Home as an Administrator-In-Training facility and for approval to function as a preceptor. All facts, statements and answers contained in this application are true and correct, to the best of my knowledge. I have not omitted any information which might be of value to the Board in determining the qualifications of this Nursing Home, whether it is called for or not, and I understand that any falsification, omission or withholding of information or facts concerning the home's qualifications shall be sufficient to bar it from this or any future certification given by the Tennessee State Board of Examiners for Nursing Home Administrators as an A.I.T. site.

______________________________ ______________________
Signature of Administrator Date

County of ______________________, State of ____________________.

Sworn to and subscribed before me by the above this _______, day of __________________, ______.

____
Notary Public

(SEAL)

My Commission Expires: ______________________________

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ADMINISTRATOR-IN-TRAINING

PROGRESS REPORT NUMBER: _______________

Name of A.I.T.: ______________________________

Name of Preceptor: ______________________________

Training Site: ______________________________

Date A.I.T. program began: ______________________________

Dates covered by this report: ______________________________

1. List assignments and departments with time spent in each: ______________________________

____

2. Summary of learning experiences: ______________________________

____

3. Brief analysis of any problems observed, new experiences, insights gained: ______________________________

____

4. Statement of any problems that arose during the period: ______________________________

____

5. Visits outside the facility, educational conferences attended: ______________________________

____

I certify, to the best of my knowledge that the information presented is true and accurate and I have had at least four (4) hours of face-to-face training with this A.I.T. each week of this reporting period.

______________________________ ______________________________
Signature of Preceptor Date

Progress reports must be submitted every 2 or 3 months. **Make extra copies of this page.** Additional comments may be made on a separate sheet of paper. **(Do not change any party of this form.)**

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Evaluation Report of the Six (6) Month A.I.T. Program
Must be in BENHA Office for Approval by the FULL Board
This Evaluation Report must be submitted with the third (3rd) and Final Report

I, ____, Preceptor for _______________________________,

certify that he/she has successfully completed the Administrator-in-Training program at:

____ Nursing Home.

I certify that I have had at least four (4) hours face-to-face training with this A.I.T. each week of the training.

The Administrator-in-Training program began on ___________________ and was completed on ___________________.

During this period, there was a total of __________ hours spent in the training program. The hours were divided as follows:

Department	Hours
Administration	________________________________
Activities	________________________________
Bookkeeping	________________________________
Business Office	________________________________
Dietary	________________________________
Housekeeping	________________________________
Laundry	________________________________
Maintenance	________________________________
Medical Records	________________________________
Nursing	________________________________
Social Services	________________________________
Other: ________________	________________________________
______________________	________________________________
_________________________	________________________________
	Total Hours: ____________________________

On a separate sheet of paper, please evaluate this prospective administrator. The Board needs your evaluation of the A.I.T.'s strengths and weaknesses in each of the above areas in order to properly guide him/her toward licensure. All reports, evaluation report, evaluation of A.I.T.'s strengths and weaknesses and recommendation letter to sit the NAB examination must be in the BENHA Office before the applicant can be approved to sit for the examination.

____   ________________________________

Signature of Preceptor   Date