South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of
Long Term Health Care Administrators
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COMMUNITY RESIDENTIAL CARE FACILITY ADMINISTER-IN-TRAINING FINAL REPORT

Report must be submitted within ten (10) days of AIT Program Completion

AIT Participant Name:_____ AIT Participant No.:_____

Preceptor Name:_____ Facility Name:_____

Preceptor License Number:_____ License Type: ☐ Community Residential ☐ Dual License

Phone:_____ Email:_____

Preceptor's Address:_____

AIT Program Completion Date:_____

This report certifies that the AIT Participant has successfully completed the requirements of the South Carolina Board of Long Term Health Care Administrator AIT Program. The AIT Participant spent a total of _____ months in the training program. The times was divided as follows:

DEPARTMENT	WEEKS/DAYS	DATE COMPLETED
ADMINISTRATION		
HUMAN RESOURCES		
MEDICAL/RESIDENT RECORDS		
ACTIVITIES		
SOCIAL SERVICES/ADMISSIONS		
BUSINESS OFFICE		
DIETARY		
HOUSEKEEPING/LAUNDRY		
MAINTENANCE/ENVIRONMENTAL		
OTHER – *detail in section below*		

AIT PARTICIPANT EVALUATION

Please provide a narrative evaluation of the AIT participant's strength and weaknesses as well as any other comments you have regarding this AIT participant or the AIT program.

AIT PROGRAM EVALUATION

1. Was the NAB Preceptor Training Modules helpful? ☐ Yes ☐ No

   Comments:

2. Please rate the experience of working with the Board of LTHCA:

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

   Comments:

3. Please rate the experience of working with an AIT in your facility:

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

   Comments:

4. Do you plan to continue as a Preceptor?

   Comments:

5. Would you recommend the AIT Program to other Administrators? ☐ Yes ☐ No

   Comments:

6. Please provide any suggestions or recommendations you have for improving the AIT Program:

_____

_____

_____

_____

AFFIDAVIT

I am the person described and identified, of good moral character, and the person named as "Preceptor" in this report. I have carefully read the questions in the report and have answered them completely, without reservation of any kind and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this report I hereby agree that such act shall constitute the cause for dismissal from the Administrator-In-Training Program as a preceptor, under the Board of Long Term Health Care Administrators.

Signature:_____ Date: _____

PRIVACY DISCLOSURE

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.