



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 ADMINISTRATOR
ADMINISTRATOR-IN-RESIDENCY (AIR) AFFIDAVIT
3-MONTH PROGRAM FINAL REPORT**

This form must be completed by the licensed preceptor and submitted within thirty (30) days of the AIR Program Completion

FACILITY INFORMATION

Facility Name: _____ Facility License No.: _____

Full Address: _____ Phone: _____

Preceptor Name: _____ License No.: _____

AIR PARTICIPANT INFORMATION

Full Name _____ AIR Permit No.: _____

Enrollment Period: From: _____ To: _____ Completion Date: _____
(mm/dd/yyyy) (mm/dd/yyyy)

SUBJECT

	Proposed Hours	Hours
ADMINISTRATION	100	
HUMAN RESOURCES	35	
HEALTH CARE SERVICES	70	
REHABILITATION	15	
MEDICAL / RESIDENT RECORDS	15	
ACTIVITIES	10	
SOCIAL SERVICES / ADMISSIONS	15	
BUSINESS OFFICE	50	
DIETARY	15	
HOUSEKEEPING / LAUNDRY	15	
MAINTENANCE / ENVIRONMENTAL	20	
OTHER:		
TOTAL HOURS:	360	0

PRECEPTOR ATTESTATION

I, the below named preceptor, first being duly sworn, declare that all information provided by me herein is true to the best of my knowledge.

Print Preceptor Name

Signature of Preceptor

Sworn to and subscribed before me this _____ day of _____, 20 _____.

Notary Signature: _____

Print Notary Name: _____

{Seal}

Notary Public for the State of: _____

Commission Expiration Date: _____

**Community Residential Care Facility Administrator
Administrator-in-Residency (AIR) Evaluation Report**

AIR Participant Name: _____

Preceptor Name: _____

1. Were the NAB Preceptor Training Modules helpful?

☐ Yes ☐ No

Comments:

2. Is the AIR participant ready to participate in the CRCFA licensure examination?

☐ Yes ☐ No

3. Does the AIR participant possess the knowledge, skills, and ability to oversee/manage or direct a long term care facility?

☐ Yes ☐ No

Comments:

4. Do you, as a preceptor, recommend that the participant's period as an AIR be approved by the Board as meeting the requirements for licensure?

☐ Yes ☐ No

Comments:

5. Please rate the experience of working with an AIR participant in your facility:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Comments:

6. In general, what is your overall rating of the AIR participant:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Comments:

7. Please provide any suggestions or recommendations you have for improving the AIR Program.

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

AFFIDAVIT:

AIR Participant:

I affirm that I have discussed this evaluation with the Preceptor of my Administrator-in-Residency Program and I certify that the information obtained is true and correct.

AIR Participant Signature: _____

Date: _____

Preceptor:

I affirm that I have discussed this evaluation with the above-named AIR Participant. I certify that I am a licensed Community Residential Care Facility Administrator in good standing, and the person named as "Preceptor" in this report. I have personally supervised the AIR program for the participant listed above, for licensure as a Community Residential Care Facility Administrator. 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-Residency Program as a preceptor, under the Board of Long Term Health Care Administrators.

Preceptor Signature: _____

Date: _____