



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) PROGRAM
PARTICIPANT/ PRECEPTOR AGREEMENT**

FACILITY INFORMATION

Facility Name: _____ Facility License No.: _____

Preceptor Name: _____ License No.: _____

AIR PARTICIPANT INFORMATION

Full Name _____ AIR Permit No.: _____

License Type: ☐ Community Residential Care Facility Administrator ☐ Dual License

The above listed AIR participant and AIR preceptor have agreed to participate in an AIR Program approved by the Board of Long Term Health Care Administrators (LTHCA). The program will be conducted at the SC DPH licensed facility listed above, commencing on _____ and will last a period of _____ months.

PROGRAM PROPOSAL

Listed below are the suggested hours to be spent in each area of practice. Complete the following section in accordance with the program structure most appropriate for the AIR. All programs require Board approval prior to implementation.

DEPARTMENT	3-MONTH PROGRAM Bachelor's Degree	6-MONTH PROGRAM Health-related Associate Degree	9-MONTH PROGRAM Associate degree in a non- health-related field or licensed LPN
ADMINISTRATION	100	200	300
HUMAN RESOURCES	35	75	100
HEALTH CARE SERVICES	70	150	200
REHABILITATION	15	30	50
MEDICAL/RESIDENT RECORDS	15	35	50
ACTIVITIES	10	20	40
SOCIAL SERVICES/ADMISSIONS	15	30	50
BUSINESS OFFICE	50	100	150
DIETARY	15	30	50
HOUSEKEEPING/LAUNDRY	15	25	40
MAINTENANCE/ENVIRONMENTAL	20	25	50
OTHER – detail in section below			
TOTAL HOURS	360	720	1080

SPECIAL PROJECTS OR ACTIVITIES:

All special projects or activities to be completed during the course of the AIR Program must be detailed below. There are several suggested activities in the NAB AIR Manual: AIR Model Standards Covering the Domains of Practice.

Additionally, AIR preceptors and participants may wish to develop a special project that does not appear in the NAB Manual.

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

ATTESTATION

By signing the affidavit below, the two parties acknowledge and agree to the following:

- That no AIR program may begin until Board approval is received.
- To follow the standards and guidelines set forth by the Board and to submit the required reports along with any special reports that may be requested.
- That enrollment in an AIR program and successful completion thereof does not guarantee approval to take the South Carolina or NAB Community Residential Care Facility Administrator License Examination.
- That a Preceptor shall not train an employer or supervisor.
- That the Preceptor's final report and evaluation will become part of the AIR participant's permanent record with the Board of LTHCA.

PRECEPTOR'S ATTESTATION:

I, _____, am the person described and identified in all documents presented in support of this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations 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 application I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice nursing home administration and/or community residential care facility administration in South Carolina.

Signature: _____

Date: _____

AIR PARTICIPANT ATTESTATION:

I, _____, am the person described and identified in all documents presented in support of this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations 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 application I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice nursing home administration and/or community residential care facility administration in South Carolina.

Signature: _____

Date: _____