



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) MONTHLY REPORT**

Reports must be received by the 5th of each month. The AIR daily hours log must be attached to the report. Monthly reports submitted without the log will not be processed.

FACILITY INFORMATION

Facility Name: _____ Facility License No.: _____

Preceptor Name: _____ License No.: _____

AIR PARTICIPANT INFORMATION

Full Name _____ AIR Permit No.: _____

Reporting Period: From: _____ To: _____

ASSIGNMENTS *(If additional space is needed, attach a separate sheet of paper)*

Assignment Summary: _____ **Department:** _____ **Hours:** _____

Description:

Assignment Summary: _____ **Department:** _____ **Hours:** _____

Description:

Assignment Summary: _____ **Department:** _____ **Hours:** _____

Description:

Assignment Summary: _____ Department: _____ Hours: _____

Description:

Assignment Summary: _____ Department: _____ Hours: _____

Description:

PROBLEMS AND RESOLUTIONS

List any problems that arose and provide description of resolution:

OUTSIDE EXPERIENCES

List any outside experiences (visits, meetings, etc.)

PRECEPTOR ATTESTATION

I certify to the best of my knowledge that the information reported above and on the daily hours log is true and accurate and that I have met at least weekly with the listed AIR participant.

Preceptor Signature: _____

Date: _____