



South Carolina Department of Labor, Licensing and Regulation  
**South Carolina Board of  
Long Term Health Care Administrators**  
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**DUAL NURSING HOME & COMMUNITY RESIDENTIAL CARE FACILITY ADMINISTRATOR  
ADMINISTRATOR-IN-RESIDENCY (AIR) AFFIDAVIT  
7-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: \_\_\_\_\_

**SUBJECT**

|                                | <b>Proposed<br/>Hours</b> | <b>Hours</b> |
|--------------------------------|---------------------------|--------------|
| ADMINISTRATION                 | 200                       |              |
| HUMAN RESOURCES                | 50                        |              |
| NURSING / HEALTH CARE SERVICES | 200                       |              |
| REHABILITATION                 | 50                        |              |
| MEDICAL / RESIDENT RECORDS     | 50                        |              |
| ACTIVITIES                     | 50                        |              |
| SOCIAL SERVICES / ADMISSIONS   | 50                        |              |
| BUSINESS OFFICE                | 50                        |              |
| DIETARY                        | 50                        |              |
| HOUSEKEEPING / LAUNDRY         | 40                        |              |
| MAINTENANCE / ENVIRONMENTAL    | 50                        |              |
| OTHER:                         |                           |              |
| <b>TOTAL HOURS:</b>            | 840                       | 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: \_\_\_\_\_

**Dual Nursing Home & Community Residential Care Facility  
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 Dual NHA 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 Nursing Home 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 Dual Nursing Home and 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: \_\_\_\_\_