



South Carolina Department of Labor, Licensing and Regulation  
**South Carolina Board of  
Long Term Health Care Administrators**  
110 Centerview Dr. • Columbia • SC • 29210  
P.O. Box 11329 • Columbia • SC 29211-1329  
Phone: 803-896-4544 • Contact.LTHCA@llr.sc.gov • Fax: 803-704-6775  
www.llr.sc.gov/lthc

**NURSING HOME ADMINISTRATOR  
ADMINISTRATOR-IN-RESIDENCY (AIR) AFFIDAVIT  
9 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                 | 300  |   |
| HUMAN RESOURCES                | 100  |   |
| NURSING / HEALTH CARE SERVICES | 200  |   |
| REHABILITATION                 | 50   |   |
| MEDICAL / RESIDENT RECORDS     | 50   |   |
| ACTIVITIES                     | 40   |   |
| SOCIAL SERVICES / ADMISSIONS   | 50   |   |
| BUSINESS OFFICE                | 150  |   |
| DIETARY                        | 50   |   |
| HOUSEKEEPING / LAUNDRY         | 40   |   |
| MAINTENANCE / ENVIRONMENTAL    | 50   |   |
| OTHER:                         |      |   |
| <b>TOTAL HOURS:</b>            | 1080 | 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: \_\_\_\_\_

**Nursing Home 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 NHA 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 Nursing Home 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: \_\_\_\_\_