

## General Information

(1) An Administrator-in-Training is a supervised internship during which the Administrator-in-Training (the AIT) works under the guidance and supervision of a preceptor, a licensed administrator meeting the qualifications set out in the requirements for preceptors. The internship is a unique phase of education consisting of the supervised practice of nursing home administration in the environment of the nursing home, with continued instruction in the skills and art of nursing home administration. In keeping with the philosophy of continued improvement in the quality of professionalism in the field of nursing home administration, the internship is considered an essential part of the education of a Nursing Home Administrator. With this concept in mind, it is evident that the internship can be conducted only in those nursing homes in which the educational benefits to the intern are considered of paramount importance, with the service benefits to the nursing home of secondary importance.

(2) The satisfactory completion of a 1,000 hour AIT program will satisfy the experience requirement set forth in rule 620-X-5-.02 (f).

(3) An applicant for the AIT program must meet those qualifications established by Code of Alabama Section 34-20-9, which are in effect at the time of application, and pay the application fee as determined by the Board.

(4) Preceptors must submit an outline of their proposed AIT program for review and approval by the Board.

(5) The Board must approve each facility at which the training will take place.

(6) The training must be under the full-time supervision of the preceptor.

(7) The AIT shall serve his/her training in a normal workweek, containing a minimum of 20 hours, with not less than eight hours to be served daily between the hours of 7:00 a.m. and 10:00 p.m., except that during the year a minimum of 40 hours and a maximum of 160 hours are to be served between 10:00 p.m. and 7:00 a.m.

(8) The AIT program shall begin on the first day of the month following the approval of the Board.

(9) The AIT and the Preceptor shall sign an agreement acknowledging to each other and the Board that the training shall be in accordance with these rules. The agreement shall contain any other agreements between the AIT and the Preceptor concerning the training.

(10) The AIT shall be allowed two weeks leave for military training, two weeks leave for vacation, and reasonable sick leave.

(11) The Board may approve a temporary discontinuance of the training for up to one year, but the AIT shall only retain credit for those quarters completed and for which reports have been submitted and approved by a Board representative. If for any reason the approved preceptor is no longer able to supervise the AIT at the facility, the AIT may petition the Board for the appointment of an interim preceptor pending the approval of a new preceptor by the Board.

(12) The Board will approve an interruption of an AIT program for the compulsory service of the AIT in the armed forces of the United States. The AIT may resume his/her training at any time within one year of his/her discharge from active duty.

(13) The AIT and the Preceptor must report any discontinuance of training to the Board within ten (10) days.

(14) A rotation through the various departments and duties in the nursing home are essential to the proper completion of the training. An AIT shall not, during the normal working hours of his/her program, fill a specific, specialized position in the nursing home.

(15) A Board representative may visit a nursing home for the purpose of surveying the AIT program. The Board may require the AIT to do further work toward meeting objectives or attaining the core of knowledge, or to work with a different Preceptor, if reports and progress in the program are inadequate.

(16) No credit shall be given by the Board for time served by an individual in an unapproved AIT program, or for time served under the supervision of a preceptor who has not been approved by the Board, or for time spent in an approved program under an approved preceptor until such time as the applications have been properly filed with the Board.

#### Preceptor

(1) The Board will approve persons to act as preceptors in AIT programs based on information submitted to the Board. The approval shall be effective for a period of three years, after which the preceptor must reapply. However, the Board may disapprove a preceptor for a training program who has failed to remain in compliance with these requirements. The Board may disapprove a preceptor at any time for good cause.

(2) Each person desiring to be a preceptor must submit an application showing:

(a) his/her name, address, and age;

(b) that he/she has been a licensed and practicing nursing home administrator in Alabama for at least three years, or has been a licensed nursing home administrator for at least two years in another state and has been licensed and practicing in Alabama for at least one year, and that no disciplinary action has been taken against him/her in the last three years;

(c) the states and dates of issuance of all his/her professional licenses, including those as a nursing home administrator; and

(d) the nursing home facilities at which the applicant has been in direct management control as administrator within the last three years.

(3) The preceptor-applicant must show that his/her education, experience, and knowledge qualify him/her to supervise the training of an AIT. The preceptor-applicant must attend a preceptor training seminar approved by the board prior to becoming a preceptor. The preceptor-applicant's certificate of attendance for the preceptor training program must not be more than one year old before applying to become a preceptor.

(4) The preceptor shall be of good moral character.

(5) A preceptor may supervise training of a member of his/her immediate family if they receive Board approval prior to the start of the program.

(6) A preceptor must be in direct management control of the facility or facilities at which the training is to take place.

(7) A person desiring to be a preceptor must apply and qualify under the terms of this rule, notwithstanding an approval under previous rules.

#### Facility at Which Training Takes Place

(1) Each application for approval of a training program shall include an application for approval of each facility at which the training will take place.

(2) The application form will request general information about the facility which will include its address, the names, employment dates, work hours, and the license numbers of registered or licensed professionals which head the various departments, and the licensed bed capacity.

(3) The application must include a copy of the latest survey report and any plans for correction. The survey report must show that the facility is currently licensed by the Department of Health, Division of Licensure and Certification and a nursing facility and has no serious operating deficiencies.

(4) The facility teaching staff shall be composed of personnel whose professional and moral integrity are unquestioned, who are proficient in the field of practice to which they devote themselves, who give careful attention to their duties and who are willing to assume responsibility individually and as a group for providing ample instruction to the AIT and to assist them in their work.

#### Domains of Practice, Objectives, Reports

The Administrator-in-Training Program shall cover the domains of practice, as established by the National Association of Boards of Examiners for Nursing Home Administrators, Inc. (NAB).

(1) The training plan for the program shall be prepared by the preceptor and the trainee prior to the start of the program. This training plan shall include:

(a) An individualized schedule showing time allotted for each department of the nursing home facility (i.e., nursing, dietary, housekeeping, business office, management and supervisory techniques, etc.).

(b) Time allotted for the AIT's participation in council meetings, state association meetings, staff meetings, etc.

(2) The preceptor and the trainee must file quarterly reports with the Board. Each report shall be co-signed by the preceptor and the trainee, and should be filed one week after the completion of each 25% segment of the program. The quarterly reports should contain a synopsis of the areas covered in the program and any relevant learning experiences. The reports should show how the trainee used the following methods to further his/her training.

(a) On-the-job experience;

(b) meetings attended;

(c) surveys completed;

(d) written reports;

(e) visits to other facilities; and

(f) educational seminars.

(3) Nothing in this rule is intended to preclude any preceptor from requiring any additional areas in the program, objectives or reports.

(4) At the completion of his/her AIT program, the facility shall furnish the intern with a certificate of service, attesting to the satisfactory completion of his/her training program. A copy of the certificate shall be forwarded to the Board. The nursing home facility may withhold such certificate only if the AIT fails to complete his/her AIT program or if his/her performance has been such as to indicate that he/she is unfit to practice as a nursing home administrator.

(5) It shall be the duty of the AIT to inform the Board of any violation by the facility of any provision of the program approved by the Board or any violation of the laws or rules of the Board governing nursing home administrators. Failure to so inform the Board may result in the disapproval of the AIT's application for licensure as a nursing home administrator.

Alabama Board of Examiners of Nursing Home Administrators  
4156 Carmichael Road, Montgomery, Alabama 36106  
(334) 271-2342

AIT PROGRAM OUTLINE - 200 HOUR

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Proposed AIT Beginning Date: \_\_\_\_\_ Proposed date of Completion: \_\_\_\_\_

**RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 68 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.*

NURSING \_\_\_\_\_ SOCIAL SERVICES \_\_\_\_\_

DIETARY \_\_\_\_\_ RECREATION/VOLUNTEERS \_\_\_\_\_

MEDICAL RECORDS \_\_\_\_\_ REHABILITATION SERVICES \_\_\_\_\_

MEDICAL/ALLIED HEALTH \_\_\_\_\_ PHARMACEUTICAL PROGRAM \_\_\_\_\_

**HUMAN RESOURCES: (A minimum of 28 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.*

ADMINISTRATION \_\_\_\_\_

**FINANCE: (A minimum of 26 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.*

BUSINESS \_\_\_\_\_

**PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 27 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.*

HOUSEKEEPING/LAUNDRY \_\_\_\_\_ MAINTENANCE \_\_\_\_\_

**LEADERSHIP AND MANAGEMENT: (A minimum of 44 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.*

**OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_**

**TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_**

**TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:**

I certify that the AIT whose signature appears below has agreed to complete this AIT program of \_\_\_\_\_ hours under my personal supervision.

\_\_\_\_\_  
(Signature of Preceptor)

AL NHA License # \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)

**Appendix A – Form 19**  
**Alabama Board of Examiners of Nursing Home Administrators**  
**4156 Carmichael Road, Montgomery, Alabama 36106**  
**(334) 271-2342**

**CERTIFICATION OF PROGRAM COMPLETION - 200 HOUR PROGRAM**

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

DATE PROGRAM BEGAN: \_\_\_\_\_ DATE PROGRAM COMPLETED: \_\_\_\_\_

**RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 68 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.*

**HUMAN RESOURCES: (A minimum of 28 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.*

**FINANCE: (A minimum of 26 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.*

**PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 27 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.*

**LEADERSHIP AND MANAGEMENT: (A minimum of 44 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.*

**OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_**

**TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_**

***TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:***

I certify that the AIT whose signature appears below has satisfactorily completed this AIT program of \_\_\_\_\_ hours under my personal supervision.

Narrative evaluation of suitability for licensure as a nursing home administrator:

\_\_\_\_\_  
(Signature of Preceptor)

AL NHA License # \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)

Alabama Board of Examiners of Nursing Home Administrators
4156 Carmichael Road, Montgomery, Alabama 36106
(334) 271-2342

AIT PROGRAM OUTLINE - 500 HOUR

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: \_\_\_\_\_ Date \_\_\_\_\_
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Proposed AIT Beginning Date: \_\_\_\_\_ Proposed date of Completion: \_\_\_\_\_

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 165 hours) TOTAL HOURS \_\_\_\_\_

Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

NURSING \_\_\_\_\_ SOCIAL SERVICES \_\_\_\_\_
DIETARY \_\_\_\_\_ RECREATION/VOLUNTEERS \_\_\_\_\_
MEDICAL RECORDS \_\_\_\_\_ REHABILITATION SERVICES \_\_\_\_\_
MEDICAL/ALLIED HEALTH \_\_\_\_\_ PHARMACEUTICAL PROGRAM \_\_\_\_\_

HUMAN RESOURCES: (A minimum of 70 hours) TOTAL HOURS \_\_\_\_\_

Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

ADMINISTRATION \_\_\_\_\_

FINANCE: (A minimum of 65 hours) TOTAL HOURS \_\_\_\_\_

Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

BUSINESS \_\_\_\_\_

PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 63 hours) TOTAL HOURS \_\_\_\_\_

Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

HOUSEKEEPING/LAUNDRY \_\_\_\_\_ MAINTENANCE \_\_\_\_\_

LEADERSHIP AND MANAGEMENT: (A minimum of 110 hours) TOTAL HOURS \_\_\_\_\_

Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:

I certify that the AIT whose signature appears below has agreed to complete this AIT program of \_\_\_\_\_ hours under my personal supervision.

\_\_\_\_\_  
(Signature of Preceptor)

AL NHA License # \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)

Alabama Board of Examiners of Nursing Home Administrators  
4156 Carmichael Road, Montgomery, Alabama 36106  
(334) 271-2342

**CERTIFICATION OF PROGRAM COMPLETION - 500 HOUR PROGRAM**

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

DATE PROGRAM BEGAN: \_\_\_\_\_ DATE PROGRAM COMPLETED: \_\_\_\_\_

**RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 165 hours) TOTAL HOURS \_\_\_\_\_**  
*Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.*

**HUMAN RESOURCES: (A minimum of 70 hours) TOTAL HOURS \_\_\_\_\_**  
*Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.*

**FINANCE: (A minimum of 65 hours) TOTAL HOURS \_\_\_\_\_**  
*Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.*

**PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 63 hours) TOTAL HOURS \_\_\_\_\_**  
*Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.*

**LEADERSHIP AND MANAGEMENT: (A minimum of 110 hours) TOTAL HOURS \_\_\_\_\_**  
*Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.*

**OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_**

**TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM:**

***TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:***

I certify that the AIT whose signature appears below has satisfactorily completed this AIT program of \_\_\_\_\_ hours under my personal supervision.

Narrative evaluation of suitability for licensure as a nursing home administrator:

\_\_\_\_\_  
(Signature of Preceptor)

AL NHA License # \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)



**Alabama Board of Examiners of Nursing Home Administrators**  
**4156 Carmichael Road, Montgomery, Alabama 36106**  
**(334) 271-2342**

**AIT PROGRAM OUTLINE - 1000 HOUR**

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Proposed AIT Beginning Date: \_\_\_\_\_ Proposed date of Completion: \_\_\_\_\_

**RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 330 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.*

NURSING	_____	SOCIAL SERVICES	_____
DIETARY	_____	RECREATION/VOLUNTEERS	_____
MEDICAL RECORDS	_____	REHABILITATION SERVICES	_____
MEDICAL/ALLIED HEALTH	_____	PHARMACEUTICAL PROGRAM	_____

**HUMAN RESOURCES: (A minimum of 140 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.*

ADMINISTRATION \_\_\_\_\_

**FINANCE: (A minimum of 130 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.*

BUSINESS \_\_\_\_\_

**PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 125 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.*

HOUSEKEEPING/LAUNDRY \_\_\_\_\_ MAINTENANCE \_\_\_\_\_

**LEADERSHIP AND MANAGEMENT: (A minimum of 220 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.*

**OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_**

**TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_**

**TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:**

I certify that the AIT whose signature appears below has agreed to complete this AIT program of \_\_\_\_\_ hours under my personal supervision.

\_\_\_\_\_  
(Signature of Preceptor)

AL NHA License # \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)

Alabama Board of Examiners of Nursing Home Administrators  
4156 Carmichael Road, Montgomery, Alabama 36106  
(334) 271-2342

**CERTIFICATION OF PROGRAM COMPLETION - 1000 HOUR PROGRAM**

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

DATE PROGRAM BEGAN: \_\_\_\_\_ DATE PROGRAM COMPLETED: \_\_\_\_\_

**RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 330 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.*

**HUMAN RESOURCES: (A minimum of 140 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.*

**FINANCE: (A minimum of 130 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.*

**PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 125 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.*

**LEADERSHIP AND MANAGEMENT: (A minimum of 220 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, residents' rights, and community services.*

**OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_**

**TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_**

**TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:**

I certify that the AIT whose signature appears below has satisfactorily completed this AIT program of \_\_\_\_\_ hours under my personal supervision.

Narrative evaluation of suitability for licensure as a nursing home administrator:

\_\_\_\_\_  
(Signature of Preceptor)

AL NHA License # \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)

Alabama Board of Examiners of Nursing Home Administrators
4156 Carmichael Road, Montgomery, Alabama 36106
(334) 271-2342

AIT PROGRAM OUTLINE - 2000 HOUR

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF AIT: \_\_\_\_\_ Date \_\_\_\_\_
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Proposed AIT Beginning Date: \_\_\_\_\_ Proposed date of Completion: \_\_\_\_\_

RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 660 hours) TOTAL HOURS \_\_\_\_\_

Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.

NURSING \_\_\_\_\_ SOCIAL SERVICES \_\_\_\_\_
DIETARY \_\_\_\_\_ RECREATION/VOLUNTEERS \_\_\_\_\_
MEDICAL RECORDS \_\_\_\_\_ REHABILITATION SERVICES \_\_\_\_\_
MEDICAL/ALLIED HEALTH \_\_\_\_\_ PHARMACEUTICAL PROGRAM \_\_\_\_\_

HUMAN RESOURCES: (A minimum of 280 hours) TOTAL HOURS \_\_\_\_\_

Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.

ADMINISTRATION \_\_\_\_\_

FINANCE: (A minimum of 260 hours) TOTAL HOURS \_\_\_\_\_

Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.

BUSINESS \_\_\_\_\_

PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 250 hours) TOTAL HOURS \_\_\_\_\_

Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.

HOUSEKEEPING/LAUNDRY \_\_\_\_\_ MAINTENANCE \_\_\_\_\_

LEADERSHIP AND MANAGEMENT: (A minimum of 440 hours) TOTAL HOURS \_\_\_\_\_

Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.

OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_

TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:

I certify that the AIT whose signature appears below has agreed to complete this AIT program of \_\_\_\_\_ hours under my personal supervision.

\_\_\_\_\_  
(Signature of Preceptor)

AL NHA License # \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)

**Appendix A – Form 13**  
**Alabama Board of Examiners of Nursing Home Administrators**  
**4156 Carmichael Road, Montgomery, Alabama 36106**  
**(334) 271-2342**

**CERTIFICATION OF PROGRAM COMPLETION - 2000 HOUR PROGRAM**

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

DATE PROGRAM BEGAN: \_\_\_\_\_ DATE PROGRAM COMPLETED: \_\_\_\_\_

**RESIDENT CARE AND QUALITY OF LIFE: (A minimum of 660 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include nursing services, social services, food service, medical services, therapeutic services, recreational and activity programs, medical records, pharmaceutical program and rehabilitation services.*

**HUMAN RESOURCES: (A minimum of 280 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include recruitment, interviewing, employee selection, training, personnel policies, employee health and safety program, and employee retention.*

**FINANCE: (A minimum of 260 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include accounting, budgeting, financial planning and asset managing, and auditing.*

**PHYSICAL ENVIRONMENT AND ATMOSPHERE: (A minimum of 250 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include safety procedures, fire, disaster and emergency programs, and building and environmental management.*

**LEADERSHIP AND MANAGEMENT: (A minimum of 440 hours) TOTAL HOURS \_\_\_\_\_**

*Topics in this area should include compliance with laws and regulations and governing entities, risk management, communication, survey, certification, enforcement, quality improvement models and management information systems.*

**OTHER: \_\_\_\_\_ TOTAL HOURS \_\_\_\_\_**

**TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM \_\_\_\_\_**

**TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:**

I certify that the AIT whose signature appears below has satisfactorily completed this AIT program of \_\_\_\_\_ hours under my personal supervision.

Narrative evaluation of suitability for licensure as a nursing home administrator:

\_\_\_\_\_  
(Signature of Preceptor)

AL NHA License # \_\_\_\_\_

\_\_\_\_\_  
(Signature of AIT)

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**4156 Carmichael Road, Montgomery, Alabama 36106**  
**(334) 271-2342**

**AIT QUARTERLY REPORT FORM**

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

AIT reports are to be sent in every three months following the start of training. Prior to the end of each three month period, a report form will be sent to you for completion. The AIT report shall be used to list experience gained since the date your training started.

NAME: \_\_\_\_\_ Date \_\_\_\_\_  
(Title) (Last) (First) (Middle)

NAME OF FACILITY WHERE TRAINING IS TAKING PLACE: \_\_\_\_\_

THIS REPORT COVERS THE PERIOD FROM \_\_\_\_\_ TO \_\_\_\_\_

DURING THIS PERIOD I RECEIVED \_\_\_\_\_ HOURS OF AIT TRAINING AND I WORKED \_\_\_\_\_ DAYS PER WEEK.

For Additional Comments: use reverse side of this form and/or additional pages.

1. List assignments and departments with time spent in each:
  
2. Summary of learning experiences:
  
3. Brief analysis of any problems observed, new experiences, insights gained:
  
4. Statement of any problems that arose during the training:
  
5. Visits outside the facility, educational conferences attended:

I hereby certify that the information listed on this report form are true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
(Signature of AIT)

The training that I have listed was supervised by: \_\_\_\_\_

**TO BE COMPLETED BY THE SUPERVISING LICENSED NURSING HOME ADMINISTRATOR:**

I certify that the AIT under my supervision has had the training listed and that this AIT received \_\_\_\_\_ hours of training and worked \_\_\_\_\_ days per week during this period.

\_\_\_\_\_  
(Signature of Preceptor)

**State of Alabama Board of Examiners of Nursing Home Administrators  
4156 Carmichael Road  
Montgomery, Alabama 36106  
(334) 271-2342**

**Application for Administrator-In-Training**

Please print clearly or type all answers. If there is no sufficient space, use additional sheets and number accordingly. A copy of your AIT program, A copy of your Preceptor's application and certificate, A copy of the Application for facility training site, A copy of your college degree, and the required fee (see fee schedule), made payable to the AL BOE of Nursing Home Administrators, must be submitted with this application. **Your application will not be considered complete and therefore will not be reviewed unless all of the above have been received.**

I hereby make application for Administrator-in-Training in the State of Alabama.

Date: \_\_\_\_\_

1. Name: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)

2. Home Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

3. Business Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

4. Telephone Number: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_

5. Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

6. Are you a citizen of the United States? Yes  No  Country \_\_\_\_\_

7. Social Security Number: \_\_\_\_\_

8. Education: (a) Please circle the highest grade completed: 6 7 8 9 10 11 12

(b) Did you graduate? Yes  No  Date of Graduation \_\_\_\_\_

(c) Name of High School \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

(d) Name of College or University \_\_\_\_\_

Address \_\_\_\_\_

(e) Degree \_\_\_\_\_

(f) Major undergraduate subjects: \_\_\_\_\_

\_\_\_\_\_

(g) Major graduate university subjects: \_\_\_\_\_

\_\_\_\_\_

(h) Other educational training: Name \_\_\_\_\_

Address: \_\_\_\_\_

(Street)

(City)

(State)

(Zip)

Dates attended: From \_\_\_\_\_ To \_\_\_\_\_

Certificate Received: Yes  No

Subjects: \_\_\_\_\_

\_\_\_\_\_

9. Professional Certificates and/or licenses held. (Include such items as fellowships in American College of Hospital Administrators and American College of Health Care Administrators, MD, RN, LPN, CPA, etc. Do not include academic degrees. Give complete information for each certificate or license you hold or have ever held).

Type of certificate or license	Name of State or other authority	Year of Original issue	Year of Latest issue	Current or Latest registration number
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10. Have you ever been convicted of a felony? Yes  No

11. Have you ever been treated for illness caused by excessive use of alcohol or narcotics?  
Yes  No

12. Have you **applied** for licensure by examination in any state or states for license as a nursing home administrator? Yes  No  State(s) \_\_\_\_\_

13. Have you ever had a certificate or other professional license revoked or suspended?  
Yes  No  If yes, attach an explanation, relevant documents and a description of the current status.

14. Are you currently registered as a nursing home administrator in any other state?  
Yes  No

**Affidavit of Applicant**

\_\_\_\_\_, on oath, do promise and swear that, if my application is accepted, I will obey the laws of the State, the Rules and applications of the Alabama Board of Examiners of Nursing Home Administrators, and maintain the honor and dignity of the profession.

It is understood and agreed that, if I should fail to keep the above agreement or if I have made any false statements in this application, I may not be able to obtain an Alabama Nursing Home Administrators License.

I further state that all the statements are made by me in this application are true and correct.

\_\_\_\_\_  
Signature of Applicant

Sworn to and subscribed before me this  
\_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

My Commission Expires \_\_\_\_\_

\_\_\_\_\_  
Notary Public



Alabama Board of Examiners of Nursing Home Administrators  
4156 Carmichael Road, Montgomery, Alabama 36106  
(334) 271-2342

Application for Preceptor

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NHA License # \_\_\_\_\_ Date of Issuance \_\_\_\_\_

NAME: \_\_\_\_\_  
(Title) (Last) (First) (Middle)

DATE OF BIRTH: \_\_\_\_\_  
(Month) (Day) (Year)

ADDRESS: (Street) \_\_\_\_\_ (City) \_\_\_\_\_  
(State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_  
*Please give current home address*

TELEPHONE: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_

Have you had any disciplinary action taken against any professional license you hold? No  Yes

During the last year, have you been convicted of a felony or misdemeanor (other than minor traffic violation); entered a plea of guilty; entered a plea under a first offender provision; been a defendant in a malpractice claim or had a professional license or membership sanctioned either publicly or privately?

No  Yes  If yes, attach copy of relevant documents.

In addition to this license, I hold the following other nursing home administrator licenses:

Not Applicable

License: \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_  
(Title) (Number) (State)  
\_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_  
(Title) (Number) (State)

Please list the names, addresses, and dates of the facilities in which you have been in direct management control over the last three years. *Please list current facilities first*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list your experience that would qualify you to supervise the training of an AIT.

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Education: *Please submit a copy of all degrees and certificates you have received.*

(a) Please circle the highest grade completed: 6 7 8 9 10 11 12

(b) Did you graduate? Yes  No  Date of Graduation \_\_\_\_\_

(c) Name of High School \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

(d) Name of College or University \_\_\_\_\_

Address \_\_\_\_\_

(e) Degree \_\_\_\_\_

(f) Major undergraduate subjects: \_\_\_\_\_

\_\_\_\_\_

(g) Major graduate university subjects: \_\_\_\_\_

\_\_\_\_\_

(h) Other educational training: Name \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Dates attended: From \_\_\_\_\_ To \_\_\_\_\_

Certificate Received: Yes  No

Subjects: \_\_\_\_\_

\_\_\_\_\_

*Please submit a copy of your current resume and a copy of your Preceptor Training Certificate.*

I hereby certify that the information listed on this application are true and correct to the best of my knowledge and belief.

In witness whereof, I set my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
(Signature of Applicant)

Sworn to and Subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
(Notary Public)

My Commission Expires \_\_\_\_\_ County of \_\_\_\_\_ State of \_\_\_\_\_

**Alabama Board of Examiners of Nursing Home Administrators  
4156 Carmichael Road, Montgomery, Alabama 36106  
(334) 271-2342**

**Application for Facility Training Site**

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NAME OF FACILITY: \_\_\_\_\_

ADDRESS: (Street) \_\_\_\_\_ (City) \_\_\_\_\_  
(State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ (Fax) \_\_\_\_\_

NUMBER OF LICENSED BEDS: \_\_\_\_\_ COUNTY: \_\_\_\_\_

OWNER: \_\_\_\_\_

Please provide the following information on the facility key staff and department heads:

NAME	POSITION IN FACILITY	DATE HIRED	WORK HOURS	TYPE OF LICENSE HELD	LICENSE #

**PLEASE ATTACH THE LATEST COPY OF YOUR SURVEY REPORT (CMS 2567) WHICH INCLUDES YOUR PLAN OF CORRECTION AND A COPY OF YOUR FACILITY LICENSE ISSUED FROM THE DIVISION OF LICENSURE AND CERTIFICATION.**

Alabama Board of Examiners of Nursing Home Administrators  
4156 Carmichael Road, Montgomery, Alabama 36106  
(334) 271-2342

Application for Preceptor Recertification

(Please print clearly or type all answers - if there is not sufficient space, use additional sheets and number accordingly).

NHA License # \_\_\_\_\_ Date of Issuance \_\_\_\_\_

Preceptor License # \_\_\_\_\_ Date of Issuance \_\_\_\_\_

NAME: \_\_\_\_\_  
(Title) (Last) (First) (Middle)

DATE OF BIRTH: \_\_\_\_\_  
(Month) (Day) (Year)

ADDRESS: (Street) \_\_\_\_\_ (City) \_\_\_\_\_  
(State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_  
*Please give current home address*

TELEPHONE: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_

During the last three years, have you been convicted of a felony or misdemeanor (other than minor traffic violation); entered a plea of guilty; entered a plea under a first offender provision; been a defendant in a malpractice claim or had a professional license or membership sanctioned either publicly or privately?

No  Yes  If yes, attach copy of relevant documents.

In addition to this license, I hold the following other professional licenses: Not Applicable

License: \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_  
(Title) (Number) (State)  
\_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_  
(Title) (Number) (State)

Have you had any disciplinary action taken against any professional license you hold? No  Yes

Please list the names, addresses, and dates of the facilities in which you have been in direct management control over the last three years. *Please list current facilities first.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list the names of all the AITs in which you precepted over the last three years. *Please list current AITs first*

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***Please submit a copy of your current resume and a copy of your Preceptor Recertification Training Certificate.***

I hereby certify that the information listed on this application are true and correct to the best of my knowledge and belief.

In witness whereof, I set my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
(Signature of Applicant)

Sworn to and Subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
(Notary Public)

My Commission Expires \_\_\_\_\_ County of \_\_\_\_\_ State of \_\_\_\_\_