



South Carolina Department of Labor, Licensing and Regulation

**South Carolina Board of  
Long Term Health Care Administrators**

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[www.llronline.com/POL/LongTermHealthCare/](http://www.llronline.com/POL/LongTermHealthCare/)



**NHA ADMINISTRATOR-IN-TRAINING PERMIT RENEWAL  
APPLICATION**

**Include with your application:**

- Check or money order (no cash) in the amount of \$25 made payable to LL-Board of LTHCA. Application fee is non-refundable. A returned check fee of up to \$30, or an amount specified by law, **may** be assessed on all returned funds.

For Board Use Only	
Permit#	
Check #	
Issued	
Amount paid	

**APPLICANT INFORMATION:**

NAME: \_\_\_\_\_ Permit# \_\_\_\_\_

LAST FIRST MIDDLE

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

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) - BUSINESS PHONE: ( ) -

EMAIL ADDRESS \_\_\_\_\_

**WORK HISTORY**

List jobs held since your previous AIT Application was submitted

COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE NUMBER (BUSINESS HOURS): ( ) -

JOB TITLE: \_\_\_\_\_ DATES WORKED FROM: \_\_\_\_\_ TO: \_\_\_\_\_

DUTIES and RESPONSIBILITIES: \_\_\_\_\_

SUPERVISOR'S NAME AND TITLE: \_\_\_\_\_

COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE NUMBER (BUSINESS HOURS): ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

JOB TITLE: \_\_\_\_\_ DATES WORKED FROM: \_\_\_\_\_ TO: \_\_\_\_\_

DUTIES and RESPONSIBILITIES: \_\_\_\_\_

SUPERVISOR'S NAME AND TITLE: \_\_\_\_\_

ADDITIONAL LONG TERM CARE EXPERIENCE: \_\_\_\_\_

**AFFIDAVIT**

I, \_\_\_\_\_, am the person described and identified, of good moral character, and the person named in all documents presented in 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 of admission to the Administrator-in-Training Program under the Board of Long Term Health Care Administrators.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Signature of Notary Public \_\_\_\_\_

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

*Seal Required Here*