



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/



FINAL PRECEPTOR REPORT

AIT NAME: _____ DATE: _____

PRECEPTOR NAME: _____

FACILITY NAME: _____ PHONE: (_____) _____ - _____

PROGRAM START DATE: _____ COMPLETION DATE: _____

● **PLEASE NOTE: THIS REPORT MUST BE RECEIVED WITHIN TEN DAYS OF COMPLETION DATE** ●

This report certifies that the AIT named above has successfully completed the requirements of the South Carolina Board of Long Term Health Care Administrator AIT Program, under the supervision of the above named preceptor. The AIT spent a total of ____ months (____) weeks in the training program. The time was divided as follows:

| <u>DEPARTMENT</u> | <u>WEEKS/DAYS</u> | <u>DATE COMPLETED</u> |
|--------------------------------|-------------------|-----------------------|
| ADMINISTRATION | _____ / _____ | _____ |
| PERSONNEL | _____ / _____ | _____ |
| NURSING | _____ / _____ | _____ |
| REHABILITATION | _____ / _____ | _____ |
| MEDICAL RECORDS | _____ / _____ | _____ |
| ACTIVITIES | _____ / _____ | _____ |
| SOCIAL SERVICES/ ADMISSIONS | _____ / _____ | _____ |
| BUSINESS OFFICE | _____ / _____ | _____ |
| DIETARY | _____ / _____ | _____ |
| HOUSEKEEPING/ LAUNDRY | _____ / _____ | _____ |
| MAINTENANCE/ ENVIRONMENTAL | _____ / _____ | _____ |
| OTHER: | | |
| _____ | _____ / _____ | _____ |
| _____ | _____ / _____ | _____ |

PRECEPTOR FINAL REPORT - CONTINUED

AIT NAME: _____ DATE: _____

PRECEPTOR NAME: _____

The Board requests your assistance in evaluating this prospective administrator. Please provide a narrative evaluation of the AIT's strengths and weaknesses as well as any other comments you have regarding this AIT or the AIT program.

AFIDAVIT

I, _____ am the person described and identified, of good moral character, and the person named as "Preceptor" in this report. I have carefully read the questions in the foregoing report and have answered them completely, without reservation 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 report I hereby agree that such act shall constitute the cause for dismissal from the Administrator-In-Training Program as a preceptor, under the Board of Long Term Health Care Administrators.

Preceptor's Signature _____ Date _____

Sworn to and subscribed before me this _____ day of _____, 20_____

Signature of Notary Public _____

My Commission Expires _____

Seal Required Here