South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of
Long Term Health Care Administrators
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P.O. Box 11329 • Columbia • SC 29211-1329
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FINAL AIT 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***●

The Board of Long Term Health Care Administrators (LTHCA) requests your assistance in evaluating the AIT Program. Please discuss any issues regarding your specific program as well as the AIT Program in general that you feel the Board should know. For example: the program developed with your preceptor; the extent of your ability to exercise independent judgment; any opportunities or experiences you found especially helpful/ineffective; how prepared you now feel to assume the role of a nursing home administrator. Use both sides of the sheet as needed. **ALL INFORMATION IN THIS REPORT IS CONFIDENTIAL**

AIT SIGNATURE: _____ DATE: _____