South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of
Long Term Health Care Administrators
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ADMINISTRATOR-IN-TRAINING

MONTHLY PROGRESS REPORT NUMBER: _____

AIT NAME:_____ PRECEPTOR NAME:_____

DATE PROGRAM BEGAN:_____ FACILITY NAME:_____

DATES COVERED BY THIS REPORT: FROM _____ TO _____

- **REPORTS MUST BE RECEIVED BY THE 5th OF EACH MONTH**
- **A COPY OF THE AIT DAILY HOURS LOG FOR THE COVERED PERIOD MUST BE ATTACHED**
- **ADDITIONAL COMMENTS MAY BE MADE ON A SEPARATE SHEET OF PAPER**

LIST ASSIGNMENTS, NOTING DEPARTMENT AND TIME SPENT IN EACH:

1. SUMMARIZE LEARNING EXPERIENCES:

2. ANALYZE ANY PROBLEMS THAT AROSE AND HOW RESOLVED:

3. LIST AND DESCRIBE ANY OUTSIDE EXPERIENCES (VISITS, MEETINGS, ETC.):

I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE AND THAT I HAVE MET AT LEAST WEEKLY WITH THE AIT.

PRECEPTOR SIGNATURE: _____ DATE: _____