



South Carolina Department of Labor, Licensing and Regulation
**South Carolina Board of
 Long Term Health Care Administrators**
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llr.sc.gov/lthc

ADMINISTRATOR-IN-TRAINING PRECEPTOR RENEWAL APPLICATION

PRECEPTOR NAME: _____

FACILITY NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (____) _____ - _____ FAX NUMBER: (____) _____ - _____

The facility must have clearly defined and staffed departments, each with a designated department head. Please list the staff names where indicated below:

<u>DEPARTMENT</u>	<u>NAME OF DEPARTMENT HEAD</u>
Administration	_____
Personnel	_____
Business Office	_____
Rehabilitation	_____
Nursing	_____
Dietary	_____
Social Services/Admissions	_____
Activities	_____
Medical Records	_____
Housekeeping and Laundry	_____
Maintenance/Environmental Management	_____

DOES FACILITY ACCEPT MEDICARE? _____ DOES FACILITY ACCEPT MEDICAID? _____

DATE OF LATEST LICENSURE SURVEY: _____

DATE OF LATEST CERTIFICATION SURVEY: _____

- **Attach a copy of the latest licensure survey and the plan to correction for any deficiencies.**

AFFIDAVIT

I, _____, am the Administrator of the facility described and identified 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 as an approved facility to the Administrator-in-Training Program under the Board of Long Term Health Care Administrators. Furthermore, I have carefully read the Administrator-in-Training Program Guidelines and agree to follow the policies and procedures therein.

Administrator's Signature _____ Date _____

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

Signature of Notary Public _____

My Commission Expires _____

Seal Required Here