South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of
Long Term Health Care Administrators
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4544 • Contact.llr@llr.sc.gov • Fax: 803-896-4515
www.llronline.com/POL/LongTermHealthCare/

AIT PROGRAM PROPOSAL

AIT candidate _____ and Preceptor _____ agree to participate in an AIT Program approved by the Board of Long Term Health Care Administrators (LTHCA). The facility name and address where the AIT program will be conducted is _____ _____. The program will begin __-_____-____and will last a period of _____ months.

Listed below is the standard time to be spent in each area of practice in the nursing home facility for S.C. AITs. These figures are based on the percentages recommended by NAB for persons new to the field. An AIT with significant experience in one or more areas may request Board approval for an altered program.

Department	% of time	6 months	% of time	9 months
Administration	14%	4 wks	12%	5 wks
Personnel	8%	2 wks	5%	2 wks
Nursing	22%	6 wks	25%	10 wks
Rehabilitation	8%	2 wks	8%	3 wks
Medical records	4%	1 wk	5%	2 wk
Activities	8%	2 wks	8%	3 wks
Social Services/Admissions	8%	2 wks	8%	3 wks
Business Office	8%	2 wks	8%	3 wks
Dietary	8%	2 wks	8%	3 wks
Housekeeping/Laundry	4%	1 wks	5%	2 wks
Maintenance/Environmental	4%	1 wks	5%	2 wks
Other	4%	1 wks	3%	1 wks

PROPOSED AIT PROGRAM

Please complete the following section in accordance with the program structure most appropriate for the AIT. All programs require Board approval prior to implementation.

DEPARTMENT	WEEKS	START DATE - END DATE
ADMINISTRATION	_____	_____
PERSONNEL	_____	_____
NURSING	_____	_____
REHABILITATION	_____	_____
MEDICAL RECORDS	_____	_____
ACTIVITIES	_____	_____
SOCIAL SERVICES/ ADMISSIONS	_____	_____
BUSINESS OFFICE	_____	_____
DIETARY	_____	_____
HOUSEKEEPING/ LAUNDRY	_____	_____
MAINTENANCE/ ENVIRONMENTAL	_____	_____
OTHER:		
_____	_____(DAYS)	_____
_____	_____(DAYS)	_____
_____	_____(DAYS)	_____
_____	_____(DAYS)	_____

TOTAL TIME: _____ WEEKS

SPECIAL PROJECTS OR ACTIVITIES

The section below is to be utilized when selecting a special project to be completed during the course of the AIT program. Several activities are suggested in The NAB Administrator-in-Training Internship Manual at the end of each department section. In addition, preceptors and AITs may wish to develop a special project that does not appear in the NAB Manual.

Please indicate below the desired project(s). *If a project(s) from the NAB Manual, please reference the page number.*

1. DEPARTMENT: _____

   ACTIVITY/PROJECT: _____

   ESTIMATED TIME REQUIRED (IN HOURS OR DAYS): _____

   PAGE NUMBER (IF IN The NAB Administrator-in-Training Internship Manual): _____

2. DEPARTMENT: _____

   ACTIVITY/PROJECT: _____

   ESTIMATED TIME REQUIRED (IN HOURS OR DAYS): _____

   PAGE NUMBER (IF IN The NAB Administrator-in-Training Internship Manual): _____

3. DEPARTMENT: _____

   ACTIVITY/PROJECT: _____

   ESTIMATED TIME REQUIRED (IN HOURS OR DAYS): _____

   PAGE NUMBER (IF IN The NAB Administrator-in-Training Internship Manual): _____

By signing the affidavit below, the two parties acknowledge and agree:

- That no AIT program may begin until Board approval is received
- To follow the standards and guidelines set forth by the Board and to submit the required reports along with any special reports that may be requested
- That enrollment in an AIT program and successful completion thereof does not guarantee approval to take the South Carolina or NAB Nursing Home Administrator License Examination
- That a Preceptor shall not train an employer or supervisor
- That the Preceptor's final report and evaluation will become part of the AIT's permanent record with the Board of LTHCA

AFFIDAVIT

I am the person described and identified, of good moral character, and the person named in this agreement. I have carefully read the questions in the foregoing agreement 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 agreement, 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 or may constitute grounds for disciplinary action.

_____ Date _____
Signature of AIT

_____ Date _____
Signature of Preceptor

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

Signature of Notary Public _____

My Commission Expires _____

Seal Required Here

● ***BOARD USE ONLY***●

APPROVAL DATE: _____

SIGNATURE: _____