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South Carolina  
Department of Labor, Licensing and Regulation

Board of Long Term  
Health Care Administrators



Henry D. McMaster  
Governor

Emily H. Farr  
Director

[www.llronline.com/POL/LongTermHealthCare](http://www.llronline.com/POL/LongTermHealthCare)

**\*\*\*THIS SECTION DOES NOT INCLUDE THE ACTUAL  
APPLICATION\*\*\***

The documents indicated in this section are the required supporting documents to **accompany the online application.**

You **must complete** either the Online Application, #2; **or** scroll to Paper Applications and select the appropriate application.



South Carolina Department of Labor, Licensing and Regulation

**South Carolina Board of  
Long Term Health Care Administrators**

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**EMPLOYMENT REFERENCE –  
COMMUNITY RESIDENTIAL CARE FACILITY ADMINISTRATOR APPLICATION**

Applicant's Name: \_\_\_\_\_

The above referenced person has applied for licensure with the South Carolina Board of Long Term Healthcare Administrators. In order for the applicant to become licensed, an employment reference form must be completed by all places of employment. Timely completion of this form is requested. Completed form may be submitted to the Board via email, fax or mailed to the address listed above.

Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_

Type of Facility: \_\_\_\_\_ Facility Licensed by: \_\_\_\_\_

Facility License No.: \_\_\_\_\_ Number of Beds: \_\_\_\_\_

Licensed Administrator: \_\_\_\_\_ CRCF License No.: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Email: \_\_\_\_\_

Applicant's Job Title: \_\_\_\_\_ Applicant's Supervisor: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_ Employment Status:  Full-Time  Part-Time

**Did Applicant have Supervisory Responsibilities?**  Yes  No Number of Employees Supervised: \_\_\_\_\_

**Did Applicant have Direct Patient Care Responsibilities?**  Yes  No

Applicant's job duties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**QUESTIONNAIRE**

1. Was/Is the applicant's job performance satisfactory?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Would you be willing to rehire the applicant if a vacancy existed?  Yes  No

Comments: \_\_\_\_\_

3. Based on your knowledge of this applicant and/or personnel records, would you recommend applicant for employment as a Community Residential Care Administrator?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Were/Are you the applicant's immediate supervisor?  Yes  No

If No, what is the basis of your familiarity with applicant's job performance? \_\_\_\_\_  
\_\_\_\_\_

5. Describe the work skills and attributes that the applicant has demonstrated that would enhance their work as a Community Residential Care Facility Administrator:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DOCUMENTATION OF WORK HOURS**

Mark one of the following:

- Applicant worked part time during their period of employment. *(Complete Section A only)*
- Applicant worked a combination of part time and full time or was a full time employee during their period of employment. *(Complete Section A and Section B)*

**Section A. PART-TIME EMPLOYMENT**

1. Period(s) of part-time employment: \_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_\_ to \_\_\_\_\_

2. Shift(s) applicant worked during part-time employment: \_\_\_\_\_

3. Total number of part-time hours worked during peak hours (7 a.m. to 7 p.m.), answer 3(a) or 3(b).
  - a. Employment of 12 months or less: \_\_\_\_\_
  - b. Employment of more than one year, list total hours per year:
 

Year: _____	Hours: _____
Year: _____	Hours: _____
Year: _____	Hours: _____
  - c. Total number of hours worked per week: \_\_\_\_\_
4. Number of staff applicant supervised during part-time employment: \_\_\_\_\_

**Section B. FULL-TIME EMPLOYMENT**

1. Period(s) of full-time employment: \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_\_\_ to \_\_\_\_\_
2. Shift(s) applicant worked during full-time employment: \_\_\_\_\_
3. Total number of full-time hours worked during peak hours (7 a.m. to 7 p.m.), answer 7(a) or 7(b).
  - a. Employment of 12 months or less: \_\_\_\_\_
  - b. Total number of hours worked per week: \_\_\_\_\_
  - c. Employment of more than one year, list total hours per year:
 

Year: _____	Hours: _____
Year: _____	Hours: _____
Year: _____	Hours: _____
4. Number of staff applicant supervised during full-time employment: \_\_\_\_\_

**REQUIRED: Attach a detailed description of areas of responsibility and company job description.**

I hereby affirm that the information provided on this form and any attachments are true and accurate and I am the authorized person to provide this information by this employer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_