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.LTHCA@llr.sc.gov • Fax: 803-704-6775
llr.sc.gov/lthc

COMMUNITY RESIDENTIAL CARE FACILITY ADMINISTRATOR EMPLOYMENT TRAINING VERIFICATION FORM

Applicant Name: _____

The above-referenced person has applied for licensure with the South Carolina Board of Long Term Health Care Administrators. To become licensed, an employment training verification form must be completed by the facility's Administrator of Record or another licensed CRCF Administrator at the facility with direct knowledge of the applicant's on-site work experience.

The completed form may be submitted to Contact.LTHCA@llr.sc.gov.

Place of Employment: _____

Address: _____

Type of Facility: _____ Facility Licensed by: _____
Agency or State Board

Facility License No.: _____ Number of Beds: _____

Administrator of Record: _____ CRCF License No.: _____

Phone No.: _____ Email: _____

EXPERIENCE INFORMATION

Applicant's Job Title: _____

Employment Status: ☐ Full-Time ☐ Part-Time Dates of Employment: _____ to _____

1. Did the applicant have supervisory responsibilities? ☐ Yes ☐ No

   If yes, number of employees supervised: _____

Direct patient care specific to a resident:

1) Hands-on care of physical assistance, including, but not limited to, assistance with activities of daily living (e.g., bathing, dressing, eating, range of motion, toileting, transferring and ambulation); assistance with medical treatments and/or medication administration;
2) Assistance with physical or psychosocial assessments; and
3) Documentation, if conducted for treatment or care purposes.

2. Did the applicant have direct patient care responsibilities? ☐ Yes ☐ No

3. Indicate the number of on-site work experience hours completed: ____

I hereby affirm that the information provided on this form and any attachments are true and accurate and that I have direct knowledge of the applicant's on-site work experience in direct patient care and supervision.

Signature: _____ Date: _____

Print Name: _____ Title: _____