



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of

Long Term Health Care Administrators

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NURSING HOME ADMINISTER-IN-TRAINING MONTHLY REPORT

Reports must be received by the 5th of each month. The AIT Daily Hours Log must be attached to report. Monthly reports submitted without the log will not be processed.

AIT Participant Name: _____ AIT Participant No.: _____

Preceptor Name: _____ Facility Name: _____

Preceptor License Number: _____ License Type: Nursing Home Dual License

Dates Covered by this Report: From: _____ To: _____

ASSIGNMENTS *(If additional space is needed, attach a separate sheet of paper)*

Assignment Summary: _____ Department: _____ Hours: _____

Description: _____

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Description: _____

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Description: _____

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Description: _____

Assignment Summary: _____ Department: _____ Hours: _____

Description: _____

PROBLEMS AND RESOLUTIONS

List any problems that arose and provide description of resolution: _____

OUTSIDE EXPERIENCES

List any outside experiences (visits, meetings, etc.) _____

ATTESTATIONS

I certify to the best of my knowledge that the information reported above and on the daily hours log is true and accurate and that I have met at least weekly with the listed AIT participant.

Preceptor Signature

Date

