Version: ***August 2016***

STATE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS
P.O. Box 2649
Harrisburg, PA 17105-2649

Telephone: (717) 783-7155
Fax: (717) 787-7769
Website: www.dos.pa.gov/nursinghome
E-Mail: st-nha@pa.gov

Courier Address:
2601 North Third Street
Harrisburg, PA 17110

APPLICATION FOR APPROVAL OF ADMINISTRATOR-IN-TRAINING PROGRAM

IMPORTANT INFORMATION

Please read the following before proceeding with the application for Administrator In Training.

PLEASE NOTE: It is the responsibility of the applicant to locate a nursing home administrator and a nursing home that is willing to provide training in an Administrator-In-Training Program.

- Applicants must meet one of the following educational requirements:
    1. Have been awarded, from an accredited college or university a master's degree in nursing home administration, in hospital administrator, in public health administration or in another academic area, including social gerontology, in which there is an emphasis in related health facility administration (§39.5(b)(4)(i) of the regulations).
    2. Have been awarded a bachelor's degree from an accredited college or university (§39.5(b)(3) of the regulations).
    3. Be enrolled in the final year of a bachelor's or acceptable master's degree program at an accredited college or university.
- Applicants must be at least twenty-one years old.
- Applicants must be a citizen of the United States or duly declared their intention of becoming a citizen of the United States.

DO NOT SUBMIT THIS APPLICATION IF YOU DO NOT MEET THE REQUIREMENTS ABOVE.

ADDITIONAL INFORMATION

If you do not receive the Board's approval of your AIT program within one year from the date of your application is received, you will be required to submit another application fee.

AIT Training hours cannot be counted until the Board approves the program. Therefore, please submit your application at least 30 days prior to your anticipated start date.

APPLICATION CHECKLIST

APPLICATION DEADLINE: *AIT Training hours cannot be counted until the Board approves the program. Therefore, please submit your application at least 30 days prior to your anticipated start date.*

ALL APPLICANTS ARE REQUIRED TO:
(Check when completed)

NOTE: *ALL DOCUMENTS MUST BE SUBMITTED ON SINGLE-SIDED, 8½" x 11" PAPER. PLEASE DO* ***NOT*** *INCLUDE BINDERS, FOLDERS OR TABBED DIVIDERS.*

1. ☐ Complete pages 1, 2 and 3 of the application.
2. ☐ Application Fee: $50.00 check or money order made payable to "Commonwealth of PA."

PLEASE NOTE THE FOLLOWING:

- Application fees are not refundable.
- If you do not receive the Board's approval to sit for the examinations within one year from the date your application is received, you will be required to submit another application fee.

* A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

3. ☐ If you answered YES to any of the criminal/disciplinary action questions, please provide accurate details on separate 8 ½" x 11" sheets of paper and provide **certified** copies of court documents.

4. ☐ If any documentation submitted in connection with this application will be received in a name other than the name under which you are applying, you must submit a copy of the legal document(s) indicating the name change (i.e., marriage certificate, divorce decree which indicates the retaking of your maiden name; legal document indicating the retaking of a maiden name, or court order).

5. ☐ If applicable, the Board must receive verification of any license, certificate, permit, registration or other authorization to practice a profession or occupation directly from the state or jurisdiction. *PLEASE NOTE: The Board does NOT need to receive verification for licenses issued by one of the licensing boards within the Pennsylvania Bureau of Professional and Occupational Affairs.*

6. ☐ The Pennsylvania State Board of Examiners of Nursing Home Administrators requires each applicant for licensure to have a criminal background check completed within 90 days of submission of this application to the Board. Information about obtaining a Pennsylvania Criminal History Record can be found at the following website: https://epatch.state.pa.us/

   (If you reside outside of Pennsylvania, you must contact the State Police from your jurisdiction.)

7. ☐ You must request a transcript to be **sent directly from the accredited college or university in a sealed official school envelope** certifying the applicable education.

   OR

   If you are enrolled in your final year of your bachelor's/master's degree program, request a letter to be sent directly to the Board from the college or university providing your anticipated date of graduation.

8. ☐ You must provide a copy of your current curriculum vitae/resume.

9. ☐ Submit completed Supervising NHA Information pages which contains your supervising NHA's original signature (pages 4 & 5).

10. ☐ Submit completed Pretraining Assessment which contains you and your supervising NHA's original signatures (page 6).

11. ☐ Submit completed Training Plan (pages 7 through 20). You must indicate the number of hours that will be allocated to each area. Each subject area requires the original signature of the department manager, the supervising NHA and the applicant. TO AVOID DELAYS IN THE REVIEW/APPROVAL OF YOUR APPLICATION, PLEASE TAKE TIME TO ENSURE THAT YOUR TOTALS ARE CORRECT.

12. ☐ Submit completed Employment Status form with your original signature (page 21).

Version: ***August 2016***

STATE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

Mailing Address:
P.O. Box 2649
Harrisburg, PA 17105-2649
Telephone: (717) 783-7155
E-Mail: st-nha@pa.gov

Courier Address *(if using a mailing service that requires a street address):*
2601 North Third Street
Harrisburg, PA 17110
Fax: (717) 787-7769

APPLICATION FOR APPROVAL OF ADMINISTRATOR-IN-TRAINING PROGRAM

Application Fee: $50.00 check payable to the "Commonwealth of Pennsylvania." *Not refundable or transferable.*
A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO OR RECEIVED FROM THE BOARD FOR YOUR FUTURE REFERENCE.

ALL ENTRIES MUST BE LEGIBLE.

APPLICANT'S INFORMATION

1. Name _____
(Last) (First) (Middle)

2. Address _____
(Street)

_____
(City) (State) (Zip Code)

The address you provide is the address that will be associated with this application to which all correspondence will be mailed. Please note that licenses are ***not forwardable.***

3. Telephone _____ Fax _____

4. E-Mail Address _____

5. Date of Birth _____

6. Social Security Number _____

7. EDUCATION INFORMATION

List College/University Attended: Date of Graduation

_____ _____
Month & Year

_____ _____
Month & Year

***High School information cannot be considered for this application.**

8. Please choose whether you are requesting approval of an 800 Hour AIT Program or a 1000 Hour AIT Program. A 1000-hour AIT program is required for applicants with a bachelor's degree. An 800-hour AIT program is required for applicants with an acceptable master's degree.

☐ 800 Hour AIT Program ☐ 1000 Hour AIT Program

		YES	NO
9.	Are you a U.S. Citizen? If no, please explain and provide a statement regarding your intention of becoming a citizen of the United States. _____	☐	☐

		YES	NO
10.	Will any documentation submitted in connection with this application be received in a name other than the name under which you are applying? If you answered YES, please provide the name or names. Submit a copy of the legal document evidencing the name change (i.e., marriage certificate, divorce decree or court order). _____	☐	☐
11.	Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction? If you answered YES to the above question, please provide the profession and state or jurisdiction. Please do not abbreviate the profession. _____ _____ The Board must receive verification of any health-related license, certificate, permit, registration or other authorization to practice a profession or occupation directly from the state or jurisdiction. *PLEASE NOTE: The Board does NOT need to receive verification for licenses issued by one of the licensing boards within the Pennsylvania Bureau of Professional and Occupational Affairs.*	☐	☐
If you answer YES to any of the following questions, provide complete details as well as <u>certified</u> copies of relevant documents to the Board office.		**YES**	**NO**
12.	Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	☐	☐
13.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	☐	☐
14.	Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	☐	☐
15.	Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, include any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	☐	☐
16.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	☐	☐
17.	Do you currently engage in or have you ever engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	☐	☐
18.	Have you ever had your DEA registration denied, revoked or restricted?	☐	☐
19.	Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	☐	☐
20.	Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?	☐	☐
21.	Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	☐	☐

Version: ***August 2016***

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

Applicant's Statement:

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Applicant's Signature

Date

Version: ***August 2016***

SUPERVISING NHA INFORMATION

1. NHA Name _____
(Last) (First) (Middle)

2. License Number _____ Expiration Date: _____

3. Residence Address _____
(Street)

_____
(City) (State) (Zip Code)

4. Telephone _____ Fax _____

5. E-Mail Address _____

6. Date of Birth _____ 7. Social Security Number _____

		YES	NO
8.	Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction? If you answered YES to the above question, please provide the profession and state or jurisdiction. Please do not abbreviate the profession. _____ _____	☐	☐
If you answer YES to any of the following questions, provide complete details as well as <u>certified</u> copies of relevant documents to the Board office.		**YES**	**NO**
9.	Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	☐	☐
10.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	☐	☐
11.	Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	☐	☐
12.	Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, include any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	☐	☐
13.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	☐	☐
14.	Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	☐	☐
15.	Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	☐	☐

16.	Since your initial application or last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	☐	☐
17.	Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?	☐	☐
18.	Since your initial application or last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	☐	☐

Supervising NHA's Statement:

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Supervising NHA's Signature _____ Date _____

PRETRAINING ASSESSMENT

To be completed by applicant. In narrative format, please answer the following questions:

1. Briefly describe your educational background:

2. Briefly describe the experience you have had that you feel qualifies you to participate in an AIT program:

3. Briefly describe your motivation and initiative to participate in an AIT program:

To be completed by supervising NHA:

In narrative format, please briefly describe your judgment of the applicant's potential in an AIT program:

Applicant's signature

Supervising NHA's signature

Date

Date

Version: ***August 2016***

STATE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

Mailing Address:
P.O. Box 2649
Harrisburg, PA 17105-2649
Telephone: (717) 783-7155
E-Mail: st-nha@pa.gov

Courier Address ***(if using a mailing service that requires a street address):***
2601 North Third Street
Harrisburg, PA 17110
Fax: (717) 787-7769

TRAINING PLAN

IMPORTANT INFORMATION – The Board will review the training plan and, if approved, will return the original training plan to you with an approval letter. Once the hours have been completed, the training plan must be signed in all noted places certifying completion of the hours. ***In order to certify completion of the program, the original training plan, containing all original signatures, must be returned to the Board within 30 days of completion. PLEASE NOTE: It is recommended that you obtain the necessary signatures for completed subject areas as they are completed rather than waiting until the completion of the entire training plan.***

A 1000-hour AIT program is required for applicants with a baccalaureate degree. An 800-hour AIT program is required for applicants with a master's degree that meets §39.5(b)(4)(i) of the Board's regulations.

Indicate whether you are requesting approval for an ☐ 800 Hour AIT Program or a ☐ 1000 Hour AIT Program.

PLEASE NOTE: Training hours cannot be counted until the Board approves this Training Plan.

1. Applicant's Name _____
(Last) (First) (Middle)

2. Supervising NHA's Name _____
(Last) (First) (Middle)

3. Facility Name _____

4. Facility Address _____
(Street)

_____
(City) (State) (Zip Code)
If approved, the original training plan and approval letter will be mailed to the applicant's attention at the facility address.

5. Facility Telephone Number _____

6. Average number of hours of training per week _____
PLEASE NOTE: An AIT program may not consist of more than 60 hours per week nor less than 20 hours per week.

7. Educational Objectives.

_____

_____

_____

_____

_____

8. Training Sites or agencies involved.

_____

_____

_____

_____

9. Indicate the number of hours that will be allocated to the subject areas below:

Please note: *The minimum number of hours identified under each subject area is based upon an 800-hour AIT program. For 1000-hour AIT programs, the 200 remaining hours must be distributed as needed to obtain the best results for the applicant.*

DIRECTOR OF NURSING

Interviewing employees/orientation of new employees
Staff Patterns/Schedules
Job descriptions
In-services/meetings
Disciplinary Procedures

HOURS

_____ **I. FEDERAL, STATE, AND LOCAL HEALTH AND SAFETY REGULATIONS**

- **A.** Develop a functional knowledge of applicable laws and rules
  1. Medicare/Medicaid licensing regulations and requirements
  2. Occupational/Safety and Health
  3. Facility policies and procedures relative to state/federal laws
  4. Licensing and certification process (past facility survey reports)
  5. Residents' Bill of Rights

_____ **II. STANDARDS OF ENVIRONMENTAL HEALTH AND SAFETY**

- **A.** Etiology of communicable disease and nosocomial infections and methods of prevention
  1. Infection, Housekeeping, and Maintenance policies and procedures
  2. Personnel record documentation related to communicable diseases
  3. Attend infection control meetings
- **B.** Sanitary Procedures
  1. Review department policies and procedures
- **C.** Trainer Procedures
  1. Review department policies and procedures
- **D.** Drug handling and control
  1. Procedures regarding procurement, labeling, controlling, administration and documentation of medications.
- **E**. Life safety code
  1. Policies and Procedures
  2. Maintenance and Utilization of equipment and treatment devices (i.e. oxygen, wheelchairs, assistive devices, whirlpools)
  3. Physical and chemical restraints
- **F**. Emergency Procedures
  1. Disaster Policies and procedures (i.e. fire, tornado, chemical spills, natural disaster)

_____ **III. DIRECTOR OF ADMISSIONS/CASE MANAGER**

- **A.** Staff development techniques for sensitizing personnel to the emotional and social needs of residents
- **B.** Admissions procedures

1. Observe the admissions process of 3 residents from initial inquiry to assimilation into the facility
2. Recognize each department's role in facilitating successful adjustment
3. Role of the family

C. Room transfer issues and policies
D. Discharge planning policies and procedures

IV. PRINCIPLES OF MEDICAL CARE

A. Medical terminology and abbreviations
B. Most commonly prescribed medications
1. Therapeutic effect, adverse reactions, drug interactions
2. Distinctions between prescription and nonprescription Drugs

C. Nutrition
1. Types of diets and rationale for usage
2. Dietary policies related to the nursing department
3. Dietary and Nursing roles

D. Charting procedures
1. Patient assessment, documentation of care and observations
2. Legal issues
3. Utilization Review
4. Medical Records

E. Communication
1. Shift report between staff nurses
2. Role of Nursing Supervisor

F. Staffing Patterns
1. Scheduling process to assure adequate nursing coverage for each shift
2. Differences in nursing responsibilities on each shift
3. Issues associated with supplemental staffing
4. Staffing requirements based on a ppd. and nursing hour requirements

G. Ancillary Services
1. Referral scheduling and methods of transport

H. The Aging Process
1. Physiological changes
2. Effects of medications

V. SOCIAL SERVICES

A. Coordination of the medical and social needs of residents
B. Care Plans
C. Interdepartmental Roles
D. Residents' Council
E. Grievance Procedures
F. Family Involvement
G. Discharge Planning
H. Residents' Rights

VI. THERAPEUTIC AND SUPPORTIVE SERVICES

A. Physical therapy, occupational therapy, restorative therapy, optometry, podiatry, dentistry, chaplain.
B. Code of ethics pertaining to professional service

VII. DEPARTMENT ORGANIZATION AND MANAGEMENT/ADMINISTRATION

A. Budget
1. Staff
2. Supplies
3. Capital Expenses

B. Staffing
1. Staff
2. Supplies
3. Capital Expenses

C. Organizational Chart
1. Relationship between departments
2. Line of authority
3. Span of control

D. Performance Evaluations
1. Recognition
2. Disciplinary action
3. Orientation of new staff
4. Inservice education
5. Interviewing and hiring
6. If applicable, termination

E. Quality Assurance
1. Audits
2. Problem Solving

_____ **Total Number of Hours (minimum of 250 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

SOCIAL SERVICES

HOURS

_____ **I. POLICIES AND PROCEDURES**
- **A.** Federal/state/local health and safety laws and regulations
- **B.** Residents' Bill of Rights

_____ **II. PSYCHOLOGY OF PATIENT CARE**
- **A.** Techniques for sensitizing personnel to emotional and social needs of residents
- **B.** Related staff inservices
- **C.** Develop an understanding of the admissions procedure as it impacts residents and families
- **D.** Discharge Planning procedures
- **E.** Policies and procedures related to deaths

_____ **III. FACILITY'S TECHNIQUE FOR COORDINATING MEDICAL AND SOCIAL NEEDS OF RESIDENTS**
- **A.** Interdisciplinary Care Plan

B. Care Plans
C. Techniques for encouraging family involvement
1. Observe a family conference
2. Participate in family night

_____ **IV. THERAPEUTIC AND SUPPORTIVE CARE AND SERVICES**
A. Dentist, podiatrist, optometrist (observe and participate in their contacts with residents)
B. Review job descriptions
C. Facilities approach to meeting spiritual needs
D. Code of Ethics pertaining to professional services

_____ **V. ORGANIZATIONAL CHART**
A. Relationship and interactions with other departments
B. Roles and functions of staff
C. Budgets and budget monitoring
D. Staffing patterns (issues surrounding supplementary staff)
E. Function, operation and maintenance of departmental equipment

_____ **Total Number of Hours (minimum of 80 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

ACTIVITIES/RECREATION

HOURS

_____ **I. POLICIES AND PROCEDURES**
A. Federal/State/Local health and safety laws and regulations
B. Residents' Bill of Rights

_____ **II. PSYCHOLOGY OF PATIENT CARE**
A. Techniques for coordinating medical and social needs of residents
B. Activities programming and care plans
C. Residents Council Meeting
D. Family Involvement

_____ **III. PERSONAL AND SOCIAL CARE**
A. Techniques for coordinating medical and social needs of residents

B. Activities programming and care plans
C. Residents Council Meeting
D. Family Involvement

_____ **IV. DEPARTMENT ORGANIZATION AND MANAGEMENT**

A. Roles, functions and tasks of each department
B. Budgets and budget monitoring
C. Staffing patterns
D. Needs and problems associated with supplemental staffing
E. Interdepartmental relationships and interactions
1. Nursing
2. Social Services
3. Activities
4. Dietary
5. Housekeeping
6. Laundry
7. Physical Therapy
8. Occupational Therapy
9. Business Office
10. Human Resources
11. Maintenance
12. Volunteers

_____ **V. COMMUNITY RELATIONSHIPS**

A. Methods of enhancing community involvement through volunteer programming
1. Volunteers policies and procedures
2. Role of Volunteer Coordinator
3. Recruitment, retention and recognition of volunteers
4. Orientation of volunteers

B. Community agencies and organization
1. Interrelationships between facility and community programs
2. Community alternatives to institutional long term care

_____ **Total Number of Hours (minimum of 40 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

BUSINESS OFFICE

HOURS

_____ **I. ACQUIRE A FUNCTIONAL KNOWLEDGE OF FACILITY BUSINESS PRACTICES**

- **A.** Review facility business policies and procedures
- **B.** General ledger
  1. Accounting procedures
  2. Chart of accounts
  3. Profit and loss
  4. Balance sheets
  5. Cost reports
  6. Accounts payable policies
  7. Accounts receivable policies
  8. Payroll
- **C.** Role of Controller in Facility Operations
  1. Review annual budget statement and participate in current budgeting process
  2. Purchase order process
  3. Medicare/Medicaid/Third party reimbursement
  4. Function of all the office equipment and computer programs
  5. Main elements of general business and malpractice liability insurance
  6. Residents Accounts
  7. Participate in Medicaid audit if possible
- **D.** Budgets and budget allocations
  1. Staff cost
  2. Staffing patterns and supplemental staffing
  3. Supplies
  4. Capital expenses
  5. Budget monitoring tools
- **E.** Relationships and interactions with other departments
- **F.** Community interrelationships (i.e. Medicare/Medicaid offices/Social Security office/VA Ombudsman/Area Office on Aging

_____ **Total Number of Hours (minimum of 120 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

DIETARY DEPARTMENT

HOURS

_____ **I. REVIEW OF POLICIES AND PROCEDURES WITH RESPECT TO THEIR APPLICABILITY TO FEDERAL, STATE AND LOCAL HEALTH AND SAFETY LAWS AND REGULATIONS, INCLUDING THE RESIDENTS' BILL OF RIGHTS**

_____ **II. UNDERSTAND THE FACILITY'S PHILOSOPHY AND APPROACH TO PROVIDING GOOD NUTRITION AND SANITATION**

_____ **III. UNDERSTAND DIFFERENT TYPES OF DIETS AND THE RATIONAL FOR EACH RESIDENT**

_____ **IV. TIME SPENT IN DEPARTMENT TO COVER**

- **A.** Role of staff, functions, organizational chart
- **B.** Budget and budget allocations delineating staffing costs, supplies and expenses, capital expenses and budget monitoring tools
- **C.** Staffing patterns, needs and concerns
- **D.** Role in interdisciplinary team meetings
- **E.** Participate in menu planning, food preparation and delivery
- **F.** Understand the function, operation and maintenance of equipment in the department
- **G.** Understand federal regulations as related to the department

_____ **V. THERAPEUTIC DIETS**

- **A.** Diet order
- **B.** Resident weights
- **C.** Portion control
- **D.** Calorie Counts
- **E.** Pleasure foods

_____ **Total Number of Hours (minimum of 120 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

DIRECTOR OF MAINTENANCE

HOURS

_____ **I. REVIEW OF POLICIES AND PROCEDURES WITH RESPECT TO THEIR APPLICABILITY TO FEDERAL, STATE AND LOCAL HEALTH AND SAFETY LAWS AND REGULATIONS, INCLUDING THE RESIDENTS' BILL OF RIGHTS**

_____ **II. UNDERSTAND THE FACILITY'S PHILOSOPHY AND BUILDING CODES AND REGULATIONS**

_____ **III. OBTAIN A WORKING KNOWLEDGE OF BUILDING CODES AND REGULATIONS**

_____ **IV. OBTAIN A WORKING KNOWLEDGE OF OSHA REQUIREMENTS**

_____ **V. LIFE SAFETY CODE AND SAFETY PRECAUTIONS FOR THE PHYSICAL PLANT AND MAJOR MECHANICAL DEVICES AND EQUIPMENT**

- **A.** Policy and procedure manuals
- **B.** Program operations of devices
- **C.** Proper utilization of resources
- **D.** Preventive maintenance programs
- **E.** Safety Checks
- **F.** Record keeping

_____ **VI. OBTAIN A WORKING KNOWLEDGE OF EMERGENCY AND DISASTER POLICIES AND PROCEDURES**

- **A.** Facility emergency plans
- **B.** Community emergency plans
- **C.** Fire and evacuations drills
- **D.** Required testing and maintenance of
  1. Fire alarm system
  2. Fire Suppression System
  3. Fire extinguishers
- **E.** Participate in annual fire department and fire marshal inspections, as applicable
- **F.** Participate in safety meetings

_____ **VII. TIME SPENT IN DEPARTMENT TO COVER THE FOLLOWING**

- **A.** Role of staff, functions and organization chart
- **B.** Budget and budgeting process
  1. Staffing requirements
  2. Supplies, expense, contracted services
- **C.** Understanding the function, operation, and maintenance of equipment within the department

_____ **VIII. COMMUNITY RELATIONSHIPS AS RELATED TO THE DEPARTMENT**

- **A.** Care of Resident belongings
- **B.** Exterior Appearance of facility
- **C.** Participation in community functions and organizations

_____ **Total Number of Hours (minimum of 40 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

DIRECTOR OF HOUSEKEEPING AND LAUNDRY SERVICES

HOURS

_____ **I. REVIEW OF POLICIES AND PROCEDURES WITH RESPECT TO THEIR APPLICABILITY TO FEDERAL, STATE AND LOCAL HEALTH AND SAFETY LAWS AND REGULATIONS, INCLUDING THE RESIDENTS' BILL OF RIGHTS**

_____ **II. LEARN AND UNDERSTAND THE FACILITY'S PHILOSOPHY AND APPROACH TO PROVIDING HOUSEKEEPING AND LAUNDRY SERVICES**

_____ **III. OBTAIN A WORKING KNOWLEDGE OF OSHA CODES**
- **A.** Knowledge of MSDS
- **B.** Knowledge of Environmental Care

_____ **IV. OBTAIN A WORKING KNOWLEDGE OF INFECTION CONTROL POLCIES AND PROCEDURES**

_____ **V. TIME SPENT IN DEPARTMENT TO COVER**
- **A.** Role of staff, function, organizational chart
- **B.** Budget and budgeting process
  1. Staffing requirements
  2. Supplies, expenses and contracted services
- **C.** Role in quality assurance program
- **D.** Understand the function, operation and maintenance of equipment within the department

_____ **VI. COMMUNITY RELATIONSHIPS AS RELATED TO THE DEPARTMENT**
- **A.** Care of resident belongings

_____ **Total Number of Hours (minimum of 40 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

DIRECTOR OF HUMAN RESOURCES

HOURS

_____ **I. REVIEW OF POLICIES AND PROCEDURES WITH RESPECT TO THEIR APPLICABILITY TO FEDERAL, STATE AND LOCAL HEALTH AND SAFETY LAWS AND REGULATIONS, INCLUDING THE RESIDENTS' BILL OF RIGHTS**

_____ **II. UNDERSTAND THE FACILITY'S PHILOSOPHY AND APPROACH TO PROVIDING EFFECTIVE HUMAN RESOURCES**

_____ **III. OBTAIN WORKING KNOWLEDGE OF ALL EMPLOYEE RELATED LAWS AND REGULATIONS**

- **A.** Federal and state unemployment
- **B.** Workers compensation
- **C.** Wages and hours
- **D.** Equal employment opportunities
- **E.** Civil rights
- **F.** OSHA
- **G.** Criminal Background check

_____ **IV. EMPLOYMENT RECRUITMENT**

- **A.** Recruiting techniques
- **B.** Employee benefits
- **C.** Interviews-3 prospective employees
- **D.** Orientation-3 new employees
- **E.** Evaluation-3 current employees
- **F.** Termination-voluntary/involuntary as applicable
- **G.** Exit interviews
- **H.** Records retained and maintenance

_____ **V. TIME SPENT IN DEPARTMENT TO COVER**

- **A.** Role of staff, function, organizational chart
- **B.** Budget and budget allocations delineating staffing cost, supplies and expenses, capital expenses and budget monitoring tools
- **C.** Staffing patterns of all departments
- **D.** Prepare time sheets and payroll
- **E.** Role in quality assurance program

_____ **VI. COMMUNITY RELATIONSHIPS AS RELATED TO THE DEPARTMENT**

_____ **Total Number of Hours (minimum of 30 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

DIRECTOR OF SAFETY MANAGEMENT

HOURS

_____ **I. REVIEW OF POLICIES/PROCEDURES AS RELATED TO FEDERAL, STATE AND LOCAL HEALTH AND SAFETY LAWS AND RULES AS WELL AS RESIDENT'S BILL OF RIGHTS**

_____ **II. ACQUIRE KNOWLEDGE OF EMERGENCY PREPAREDNESS AND TRAINING, DRILLS, ETC.**

_____ **III. PSYCHOLOGY OF PATIENT CARE**
Learn techniques for sensitizing personnel to emotional and social needs of residents and families

- **A.** Understanding role of staff and function of the department
- **B.** Budgets and budget monitoring
- **C.** Relationships, interactions with other departments
- **D.** Understanding function, operation, of equipment used and other resources (i.e. Long Term Care Network)

_____ **Total Number of Hours (minimum of 40 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

COMMUNITY SERVICES/ADMINISTRATION

HOURS

_____ **I. REVIEW OF POLICIES AND PROCEDURES WITH RESPECT TO THEIR APPLICABILITY TO FEDERAL, STATE AND LOCAL HEALTH AND SAFETY LAWS AND RULES, INCLUDING RESIDENT'S BILL OF RIGHTS**

_____ **II. TIME IN DEPARTMENT TO COVER**
- **A.** Understanding roles, functions, organizational chart
- **B.** Budgets and budget allocations; delineating staff costs, supplies
- **C.** Staffing patterns; needs and problems of supplemental staffing
- **D.** Relationships, interaction with other departments

_____ **III. COMMUNITY INTERRELATIONSHIPS AS RELATED TO DEPARTMENT**
- **A.** Understand policies and procedures
- **B.** Understand the methods of enhancing community involvement through volunteer programming
- **C.** Become familiar with area activities of community agencies and organizations
- **D.** Community (external interrelationships)

_____ **Total Number of Hours (minimum of 20 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

MARKETING/ADMINISTRATION

HOURS

_____ **I. REVIEW OF POLICIES AND PROCEDURES WITH RESPECT TO THEIR APPLICABILITY TO FEDERAL, STATE AND LOCAL HEALTH AND SAFETY LAWS AND RULES, INCLUDING RESIDENT'S BILL OF RIGHTS**

_____ **II. DEVELOP AN UNDERSTANDING OF THE ADMISSIONS PROCEDURE AND THE FACILITY'S APPROACH FOR WELCOMING AND ORIENTING NEW RESIDENTS**

_____ **III. TIME SPENT IN DEPARTMENT TO COVER**

1. Understand roles and functions of organizational chart
2. Participate and observe budgets and budget monitoring
3. Staffing patterns, needs and problems of supplemental staffing
4. Relationships, interaction with other departments
5. Resources used for marketing and marketing research

_____ **Total Number of Hours (minimum of 20 hours)**

I certify that it is my intent to have the above hours completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

TO BE SIGNED AFTER COMPLETION OF HOURS

I certify that the above hours have been completed in the noted areas. I understand that false statements are made subject to the penalties of 18 Pa.C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

Signature of Department Manager _____ Date _____

Signature of Supervising NHA _____ Date _____

Signature of Applicant (AIT) _____ Date _____

Total Number of Hours for AIT Program: _____

Version: ***August 2016***

EMPLOYMENT STATUS

1. Applicant's Name _____
   (Last) (First) (Middle)

2. Facility Name _____

3. Please check either A or B, **AND** complete the time schedule below

   (A) ☐ **I <u>will not</u> be employed during any hours of the day in any position other than administrator-in-training throughout the period of my internship.**

   (B) ☐ **I <u>will</u> be employed during some hours of the day in a position other than administrator-in-training during the period of my internship.**

AIT SCHEDULE				OTHER EMPLOYMENT		
Day	**Location**	**Position**	**Hours From-To**	**Location**	**Position**	**Hours From-To**
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						

PLEASE NOTE: At least 80% of the training must occur from Monday through Friday between 7 a.m. and 7 p.m.

I certify that the information on this document is complete and accurate to the best of my knowledge and belief. I further understand that, should it be found that I have acted in any capacity other than that of administrator-in-training during the above stated training hours, part or all of said training program can be disallowed.

Applicant's Signature _____ Date _____