# Administrator In Training (AIT) Course

AHCF ARKANSAS HEALTH CARE FOUNDATION

**May 9-10, June 13-14, July 18-19, and September 11-13, 2018**
**8:30 a.m. – 4:30 p.m., AHCA Training Room, Suite 175**
**$900**
**Lunch and Materials Included**

**To register, send this completed form and $100 application fee to:**
**Mail: 1401 W. Capitol Ave., Suite 180, Little Rock, AR 72201 • Fax: 501-374-1077 • Email: registration@arhealthcare.com.**
The information contained herein, together with all attached documents, will be regarded as property of AHCA.

## Section I
Personal Information

First Name | M. | Maiden Name | Last Name | Date of Birth | Place of Birth

Mailing Address | City | State | Zip

Cell Phone | Email Address *(Confirmation and class materials will be sent to this address)* | Last 4 digits of SSN

Employer | Current Title

Facility (Skilled Nursing) Work Hours to be Completed | Preceptor Name & Title

Employer's Address | City | State | Zip

Attendee's Signature | Date

## Section II
Experience Qualifications

A. Have you been employed by a nursing facility? ☐ Yes ☐ No

B. If so, please provide this additional information regarding your employment. Add additional sheets if necessary. If not, continue on to the next page.

Facility Name | Facility's Address

City | State | Zip | Dates of Employment

Position | Summary of Duties

Facility Name | Facility's Address

City | State | Zip | Dates of Employment

Position | Summary of Duties

**C. Employment History**

Please begin with your present or most recent position and work back. Additional sheets may be attached if necessary.

Facility Name | Facility's Address

City | State | Zip | Dates of Employment

Position | Summary of Duties

Name and Title of Immediate Supervisor | Reasons for Leaving

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Facility Name | Facility's Address

City | State | Zip | Dates of Employment

Position | Summary of Duties

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Facility Name | Facility's Address

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Facility Name | Facility's Address

City | State | Zip | Dates of Employment

Position | Summary of Duties

Name and Title of Immediate Supervisor | Reasons for Leaving

# Section III

Educational Record

A. A complete and original transcript of your college credits must be provided with this application. This information will become part of the application.

| | High School | College | Graduate School | Other |
|---|---|---|---|---|
| Name | | | | |
| Location | | | | |
| Dates of Attendance | | | | |
| Grades, Years or Hours Completed | | | | |
| Type of Degree, Diploma, or Certificate | | | | |

List Field(s) of Study: _____ _____

Major Minor

B. Regulations require that all applicants have basic education or experience in the following areas. Please specify how you meet these core requirements in the grid below. List the course name, workshop, seminar, or experience in each area.

| | |
|---|---|
| Accounting/Bookkeeping | |
| Management/Supervision | |
| Personnel | |
| Writing Skills | |
| Resident Care | |

# Section IV

References and Qualifications

1. On a separate sheet of paper, please explain why you feel that you are capable or qualified to function as a nursing home administrator. Attach the explanation to the application.

2. Are you currently licensed in another state? ☐ Yes ☐ No

   If so, please indicate the state and license number: _____

   State License Number

3. Have you ever been convicted of a felony? ☐ Yes ☐ No
If so, attach a separate statement showing offense, charge, date and disposition of the case.

4. Do you have a substantiated history of exclusion from the Medicare or Medicaid program?
☐ Yes ☐ No

5. Do you agree to have and pay for a criminal background check?
☐ Yes ☐ No

6. Attach three professional reference letters from those who have knowledge of your character, work experience and ability. Not including relatives.

| | Name | Address | How long reference has known you | Phone Number |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

## Section V

Certification

**I HEREBY CERTIFY:**

- **I have read AR Statutes (1987), as amended, § 20-10-401 through 20-10-408 and the rules and regulations promulgated there under entitled "Rules and Regulations for the Licensure of Nursing Home Administrators."**
- **This application and all attached papers contain no willful misrepresentation or falsification, and the information given by me is true and complete to the best of my knowledge and belief. I am aware that should an investigation by the Arkansas Health Care Foundation reveal any such misrepresentation or falsification, it may prevent me from becoming licensed or, if I am already licensed, cause my license as a nursing home administrator to be revoked.**

_____

Signature of Applicant Date

Sworn to and subscribed before me by the above this _____ day of _____ 20 _____

_____

Notary Public Signature County State Date Commission Expires

Notary Public Seal



**For more information, please contact the Association at 501-374-4422 or AIT@arhealthcare.com.**

**1401 W. Capitol Avenue, Suite 180, Little Rock, AR 72201**
**Phone 501-374-4422 | Fax 501-374-1077**