PRECEPTOR CONTINUING EDUCATION
CREDIT APPLICATION

Return this completed form with a check or money order (made payable to NHAP) with the appropriate fee (**Continuing Education Course fee**) to the following address:

Nursing Home Administrator Program
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416

For a current *Fee List*, please visit our website at: www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/NHAPFees.aspx

Preceptor's Name		NHA License Number	Preceptor Number
Preceptor's Address (Number and Street Name)	(City)	(State)	(Zip Code)
Administrator-In-Training Name (Last)	(First)	(Middle)	
AIT's Address (Number and Street Name)	(City)	(State)	(Zip Code)
Effective Date of AIT Program	Ending Date of AIT Program	Number of CE Hours Claimed	
Name of Facility Where Training Occurred	Facility Telephone Number	Preceptor's Email Address	
Facility Address (Number and Street Name)	(City)	(State)	(Zip Code)

PLEASE NOTE:

One (1) hour of credit shall be awarded for each week in which a licensee serves as the preceptor in an approved Administrator-In-Training (AIT) program, regardless of the number of AITs concurrently in training. No more than twenty (20) classroom hours may be acquired pursuant to this subsection during a two-year licensing period.

Maintenance of the information requested on this application form is authorized by Section 1416.34(h) and Section 1416.60 of the Health and Safety Code. No items of information are voluntary; all are required. Failure to provide any of the required information will result in the application being rejected as incomplete.

☐ Fee included

I certify under the penalty of perjury within the laws of the State of California that the information obtained in this document is both true and correct.

_____
Signature of Preceptor   Date

APPLICANTS—DO NOT USE THIS SPACE BELOW—FOR NHAP USE ONLY	
☐ Cashier #:	☐ Amount $:
DATE APPROVED:	NHAP STAFF INITIALS:
INFORMATION VERIFIED FROM TRAINING REPORT? ☐ YES ☐ No	
NO. OF HOURS APPROVED:	APPROVAL NO.: