Administrator in Training (AIT) Application Instructions

Allow the Program *30 days* to process your application. You will be notified in writing if the application is incomplete.

Print the entire application and required forms. Use the checklist below to ensure you have completed and included all the required forms prior to submitting your application.

To become an Administrator in Training (AIT), you must:

- Complete an AIT application and submit all required documentation.
- Must be at least 18 years of age, be a citizen of the United State or a legal resident and have a reputable and responsible character.
- Be cleared through a background check for convictions of any crimes.
- Pay the appropriate fees established by the Program.
- Have a Baccalaureate Degree or higher; or meet work experience requirements.
- You must first receive written approval from the Nursing Home Administrator Program to begin your AIT program. Any accumulated hours prior to the written NHAP approval and start date will be void.

Administrator in Training Application Checklist

☐ APPLICATION FEE: For a current fee list, please refer to our website at: http://www.cdph.ca.gov/certlic/occupations/Pages/NursingHomeAdministrator.aspx

☐ APPLICATION: The application must be completed in its entirety with all questions answered. Failure to do so will result in an incomplete application and a deficiency letter will be mailed to you. Failure to correct the deficiencies will result in your application being deemed abandoned. You must complete, sign, and date the application. All signatures must be original.

☐ PHOTO (2x2) & IDENTIFICATION: A passport style photo must be taken and attached to the first page of the application. A copy of a government issued Identification Card, Passport, Driver's License must also accompany the photo for verification purposes.

☐ OFFICIAL TRANSCRIPT: You must submit official (unopened) transcript that evidences the completion of required college or university courses, degrees, or both. An applicant who is a member of a recognized church or religious denomination whose teachings historically prohibit the acquisition of the formal education that would otherwise be required to qualify the applicant for the AIT Program may request a written waiver of the education requirements from the department. (Per Health & Safety Code 1416.55(f))

☐ WORK EXPERIENCE: An applicant who qualifies for the AIT Program on the basis of work experience shall submit a declaration signed under penalty of perjury verifying his or her work experience. This declaration shall be signed by a licensed nursing home administrator, physician or surgeon, chief of staff, director of nurses, or registered nurse who can attest to the applicant's work experience. (Per Health & Safety Code 1416.55(g))

__ Ten years of recent full-time work experience, and a current license, as a licensed registered nurse, and the completion of a program approved AIT Program of at least 1,000 hours. At least the most recent five years of the 10 years of work experience shall be in a supervisory or director of nursing position. (Per Health & Safety Code 1416.22(a)(5)

__ Ten years of full-time work experience in any department of a skilled nursing facility, an intermediate care facility, or an intermediate care facility developmentally/disabled with at least 60 semester units (or 90 quarter units) of college or university courses, and the completion of a program approved AIT program at least 1,000 hours. At least the most recent five years of the 10 years of work experience shall be in a position as a department manager.

☐ FINGERPRINTS: All applicants are required to have their fingerprints processed via Live Scan if they reside in California. If you reside outside of California and are unable to visit California to do the Live Scan, then you must have your fingerprints processed on fingerprint cards. DO NOT complete the Live Scan or fingerprint cards until you are ready to submit your application. The Program will only accept current fingerprint clearances from the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI). Submit either A or B below with your application.

__ Completed Live Scan receipt
__ Completed fingerprint cards *(Out-of State Residents ONLY)*

☐ DOCUMENT VALIDATION: Please provide one of the following for Citizenship/Legal Resident verification.

•US Birth Certificate (certified copy from state or local vital statistics office)
•US Certificate of Birth Abroad or Report of Birth Abroad
•Federal Proof of Indian Blood Degree
•USCIS American Indian Card
•Birth Certificate or passport issued from a US Territory
•US Passport
•US Military Identification Cards (Active or reserve duty, dependent of a military member, retired member, discharged from service, medical/religious personnel)
•Common Access Card (only if designated as Active military or Active Reserve or Active Selected Reserve)
•Certificate of Naturalization or Citizenship
•USCIS US Citizen ID Card
•Permanent Resident Card

APPLICATION TO BECOME AN ADMINISTRATOR-IN-TRAINING (AIT)

INSTRUCTIONS

You may qualify for the AIT program if you have a baccalaureate degree or certain types and amounts of work experience. Applicant qualifications are set forth in Sections 1416.2(6) and 1416.55(c) of the Health and Safety Code.

If you qualify for the AIT program, it is your responsibility to arrange for the designated administrator of a skilled nursing facility or intermediate care facility, possessing a valid preceptor certificate, to supervise the program. A list of approved preceptors is provided upon receipt of a written request. When a preceptor agrees to oversee a program, complete the attached application, along with the appropriate fees, and return it to the Program at the address listed on the application.

If you indicated on your application you have been convicted of a crime, for each conviction you must submit certified copies of the arrest report, court documentation evidencing compliance with any terms of probation, restitution, or other sanctions imposed, a probation officer report, if applicable, and a certificate of rehabilitation, if applicable. Please contact the Program for additional information.

Please note: The application process must be completed within six months of the original date of application. You have one year to complete your AIT training program at the minimum training hours of 20 per week. You will complete your training prior to a year if you train more than 20 hours per week. The training year begins once you receive written approval to begin training from the Nursing Home Administrator Program (NHAP). If you have a program interruption you must contact NHAP immediately in writing. You will have one year from the date you stopped your training to restart your training program.

THE FOLLOWING ITEMS MUST ACCOMPANY THE APPLICATION:

1. A recent photo, approximately 2" x 2", clearly picturing applicant's face.
2. A check or money order payable to Nursing Home Administrator Program. Please check NHAP website for current fees: http://www.cdph.ca.gov/certlic/occupations/Pages/NursingHomeAdministrator.aspx
   Please note: fees may are subject to change each fiscal year
3. An outline of a 1,000-hour training program prepared by your preceptor based on an assessment of your individual needs. **(See notes #1 and #2.)**
4. If you qualify under the basis of ten years of work experience as a registered nurse (RN), a copy of your RN license must also accompany the application.
5. An **OFFICIAL TRANSCRIPT** must be obtained from your college/university and provided in an **unopened** envelope. (Transcripts that appear to be opened by the applicant will be rejected.) If your units earned or degree/credentials were not conferred in the United States, you must acquire a credential equivalency evaluation in lieu of providing an official transcript. Please contact the Program for additional information. **(See note #3.)**

Please do not contact the Program unless at least **45 days** have passed since you have mailed the application. If the Program approves your application, you will receive written notification.

All items of information requested on the AIT application are MANDATORY. Failure to provide any of the requested information may result in the entire package being returned and a delay in the processing of your application or the rejection of the application. The information provided will be used to determine your qualifications to enter the AIT program.

NOTE #1: The preceptor, based on a pre-training assessment of the applicant's education and experience, shall develop the 1,000-hour AIT training outline.

NOTE #2: Unless you qualify for the AIT program under one of the methods described in the Health and Safety Code, your application will not be approved. The AIT application fee is **non-refundable**.

NOTE #3: Regardless of the number of universities or colleges attended, the Program requires only one transcript indicating you were awarded an academic degree (baccalaureate or higher). Each transcript must bear the official seal of the school. Do not send: diplomas, copies of diplomas, certificates of attendance at seminars or letters of recommendation.

Upon approval of your AIT Program, a criminal record check (Live Scan form) must be completed with the Nursing Home Administrator Program as the contributing agency. Criminal record checks previously processed by another state agency or your employer do *not* satisfy the Program's criminal record clearance requirement.

IF YOU HAVE QUESTIONS, PLEASE CALL THE PROGRAM AT (916) 552-8780, OR CONTACT US VIA ELECTRONIC MAIL AT NHAP@CDPH.CA.GOV.

California Department of Public Health (CDPH)
Nursing Home Administrator Program (NHAP)
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416
(916) 552-8780 FAX (916) 552-8777
NHAP@cdph.ca.gov

In this space, attach a recent photo, sized approximately 2" by 2", clearly picturing the applicant's face.

(FOR IDENTIFICATION PURPOSES ONLY)

APPLICATION FOR AIT PROGRAM

Return this completed form with a check or money order (made payable to NHAP) with the appropriate fees to the following address:

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

For a current ***Fee List*** **and** ***Detailed Fee Analysis***, please visit our website at: www.cdph.ca.gov/certlic/occupations/Pages/NursingHomeAdministrator.aspx

APPLICANT'S NAME (Last)	(First)	(M.I)	SOCIAL SECURITY NUMBER*
MAILING ADDRESS (Number)	(Street)		WORK TELEPHONE NUMBER
(City)	(County)	(State) (Zip Code)	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	FAX NUMBER (Optional)		DATE OF BIRTH (MM/DD/YYYY)

*Social Security Number Disclosure: Pursuant to Section 666(a)(13) of Title 42 of the United States Code and California Family Code Section 17520, subdivision (d), the California Department of Public Health (CDPH) is required to collect social security numbers from all applicants for nursing home administrator licenses. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support orders upon request by the Department of Child Support Services, collection of delinquent State taxes if applicant appears on the Franchise Tax Board's top 500 delinquent taxpayers list pursuant to Business Codes Section 494.5 Subdivision (4) and for reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR, Section 61.1 *et seq.* Failure to provide your social security number will result in the return of your application. Your social security number will be used by CDPH for internal identification, and may be used to verify information on your application, to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.

ANSWER THE FOLLOWING QUESTIONS:

1. Are you a United States Citizen or legal resident? ☐ Yes ☐ No
2. Are you at least eighteen (18) years of age or older? ☐ Yes ☐ No
3. Are you now, or were you, employed as a Nursing Home Administrator? (If "Yes", fill in the information below.) ☐ Yes ☐ No

   State: _____ License #: _____ Date of expiration: _____

4. Former name(s)? (If "**Yes**" List in space below) ☐ Yes ☐ No
   A. _____
   B. _____
   C. _____
5. Have you ever pled guilty or nolo contendere to, or been convicted of, any crime (other than minor traffic violations)? ☐ Yes** ☐ No

   ***** IF THE ANSWER TO THIS QUESTION IS "YES," EXPLAIN FULLY ON A SHEET OF PAPER. PROVIDE CERTIFIED COPIES OF ARREST REPORT AND COURT DOCUMENTS THAT INCLUDE THE FOLLOWING AS APPLICABLE: CRIMINAL COMPLAINT, PLEA AND JUDGMENT, AND PROBATION REPORT. IF THESE RECORDS HAVE BEEN DESTROYED, THE PROGRAM REQUIRES A SIGNED STATEMENT TO THAT FACT ON AGENCY LETTERHEAD; FROM THE AGENCY YOU ARE REQUESTING RECORDS. A CONVICTION WILL NOT NECESSARILY DISQUALIFY YOU.***
6. Are you now or have you ever been licensed or certified by any other California state agency? (If "Yes", please complete below.)

   Agency: _____ License #: _____ Date of expiration: _____
   Agency: _____ License #: _____ Date of expiration: _____
   Agency: _____ License #: _____ Date of expiration: _____

CERTIFICATION – IMPORTANT – PLEASE READ BEFORE SIGNING – If not signed, this application may be rejected.

I certify under penalty of the perjury laws of the State of California that the information I have entered on this application (pg. 1-4) is true and correct. I further understand that any false, incomplete, or incorrect statements may result in denial of this AIT application and/or disqualification of the AIT's hours with the NHAP. I authorize the employers and educational institutions identified on this application to release any information they may have concerning my employment or education to the State of California NHAP.

APPLICANT'S SIGNATURE : _____ DATE: _____

APPLICANTS – DO NOT USE THE SPACE BELOW – FOR NHAP USE ONLY

_____	STATUS ☐Approved ☐Rejected ☐Denied	
CASH # _____	☐Unopened Transcripts	☐Training Outline
NHAP INITIALS _____	☐Fingerprints	☐AIT# ☐Preceptor Approved
AMOUNT _____	STAFF	DATE PROCESSED

APPLICANT'S NAME (Last)	(First)	(M.I.)	SOCIAL SECURITY NUMBER*

7. EDUCATION

DID YOU GRADUATE FROM HIGH SCHOOL? ☐ Yes ☐ No

IF NOT, DO YOU POSSESS A GED OR EQUIVALENT? ☐ Yes ☐ No

IF NOT, ENTER THE HIGHEST GRADE YOU COMPLETED:

UNIVERSITY OR COLLEGE NAME-AND LOCATION, BUSINESS, CORRESPONDENCE, TRADE, TECHNICAL, OR SERVICE SCHOOL	COURSE	UNITS		DIPLOMA, DEGREE OR CERTIFICATE OBTAINED	DATE COMPLETED
		SEMESTER	QUARTER		

8. **You are applying for the AIT program on the basis of (check only one):**

☐ Baccalaureate or higher degree, **complete only sections 9 and 11 of this application.**

☐ Ten (10) years of recent full-time work experience, as a registered nurse in a nursing home with at least the most recent five (5) of the ten (10) years of work experience in a supervisory position, **complete only sections 10 and 11 of this application.**

☐ Ten (10) years of full-time work experience, in any department of nursing home, with at least the most recent five (5) of the ten (10) years of work experience in a supervisory position, and sixty (60) semester units (or ninety (90) quarter units) of college or university courses, **complete only sections 10 and 11 of this application.**

9. EMPLOYMENT HISTORY – Begin with your most recent job. List each position separately.

FROM (MM/DD/YY)	TO (MM/DD/YY)	JOB TITLE/CLASSIFICATION
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME

DEPARTMENT OF NURSING HOME	FACILITY ADDRESS, CITY, STATE, ZIP CODE

DUTIES AND RESPONSIBILITIES

FROM (MM/DD/YY)	TO (MM/DD/YY)	JOB TITLE/CLASSIFICATION
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME

DEPARTMENT OF NURSING HOME	FACILITY ADDRESS, CITY, STATE, ZIP CODE

DUTIES AND RESPONSIBILITIES

APPLICANT'S NAME (Last)	(First)	(M.I.)	SOCIAL SECURITY NUMBER**

9. **EMPLOYMENT HISTORY – Begin with your most recent job. List each position separately.**

FROM (MM/DD/YY)	TO (MM/DD/YY)	JOB TITLE/CLASSIFICATION
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME

DEPARTMENT OF NURSING HOME	FACILITY ADDRESS, CITY, STATE, ZIP CODE

DUTIES AND RESPONSIBILITIES

10. **NURSING HOME WORK EXPERIENCE (Licensed NHAs, RNs and Physicians. Ten (10) year's work experience required.)**

FROM (MM/DD/YY)	TO (MM/DD/YY)	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ Yes ☐ No
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	

DEPARTMENT OF NURSING HOME	FACILITY ADDRESS, CITY, STATE, ZIP CODE

DUTIES AND RESPONSIBILITIES

CHECK APPROPRIATE BOX

☐ I am authorized and have personally verified the information from records on file at the facility	FROM: / /	TO: / /
☐ I have personal knowledge of this work experience because I work at the same facility as the applicant	FROM: / /	TO: / /
****Signature of licensed NHA, Physician, or RN** _____	**LIC #:** _____	**DATE: / /**

FROM (MM/DD/YY)	TO (MM/DD/YY)	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ Yes ☐ No
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	

DEPARTMENT OF NURSING HOME	FACILITY ADDRESS, CITY, STATE, ZIP CODE

DUTIES AND RESPONSIBILITIES

CHECK APPROPRIATE BOX

☐ I am authorized and have personally verified the information from records on file at the facility	FROM: / /	TO: / /
☐ I have personal knowledge of this work experience because I work at the same facility as the applicant	FROM: / /	TO: / /
****Signature of licensed NHA, Physician, or RN** _____	**LIC #:** _____	**DATE: / /**

APPLICANT'S NAME (Last)	(First)	(M.I.)	SOCIAL SECURITY NUMBER**

10. **NURSING HOME WORK EXPERIENCE (Licensed NHAs, RNs and Physicians. Ten (10) years work experience required.)**

FROM (MM/DD/YY)	FROM (MM/DD/YY)	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ Yes ☐ No
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	

DEPARTMENT OF NURSING HOME	FACILITY ADDRESS, CITY, STATE, ZIP CODE

DUTIES AND RESPONSIBILITIES

CHECK APPROPRIATE BOX

☐ I am authorized and have personally verified the information from records on file at the facility	FROM: / /	TO: / /
☐ I have personal knowledge of this work experience because I work at the same facility as the applicant	FROM: / /	TO: / /
****Signature of licensed NHA, Physician, or RN** _____	LIC #:	DATE: / /

11. **PRECEPTOR INFORMATION – TO BE COMPLETED BY PRECEPTOR**

PRECEPTOR'S NAME (Last)	(First)		(Middle)
NHA LICENSE NUMBER	NHA LICENSE EXPIRATION DATE	PRECEPTOR NUMBER	PRECEPTOR EXPIRATION DATE

PRECEPTOR'S PRINCIPAL JOB(S)/TITLES

NAME OF FACILITY, OFFICE OR CORPORATION			TELEPHONE NUMBER
ADDRESS OF FACILITY, OFFICE OR CORPORATION (NUMBER AND STREET)	(City)	(State)	(Zip Code)
NAME OF SNF/ICF TRAINING WILL TAKE PLACE			TELEPHONE NUMBER
ADDRESS OF SNF/ICF WHERE TRAINING WILLTAKE PLACE (NUMBER AND STREET)	(City)	(State)	(Zip Code)

NUMBER OF HOURS PER WEEK AIT WILL BE TRAINING: _____

NUMBER OF HOURS PER WEEK YOU, **AS THE PRECEPTOR**, WILL BE PERSONALLY SUPERVISING THE TRAINING OF THE AIT:

☐ Minimum 20 ☐ 30 ☐ 40 ☐ 50 ☐ Maximum 60 ☐ Other _____

☐ **I have reviewed the application package and it is complete with necessary attachments listed below.**

☐ 2 X 2 Photo

☐ Criminal Conviction Documentation (if applicable)

☐ Unopened Transcript(s) in sealed envelope

☐ 1,000 Hour AIT Training Outline

I declare under penalty of perjury under the laws of the State of California that the information furnished in section 11 is true and correct. I hereby agree to make it my personal responsibility to see that the Administrator-In-Training (AIT) receives the type and amount of training required to make him/her fully qualified to become a licensed Nursing Home Administrator. I will comply with all the requirements of the AIT program, as set forth in the rules and regulation of the State Nursing Home Administrator Program (Health and Safety Code, Chapter 2.35). I understand that failure to supervise the AIT as indiciated above will result in the AIT's training hours being disqualified and may result in suspension of my California Preceptor certificate.

PRECEPTOR'S SIGNATURE**	DATE **

All information requested by the application is required by the California Department of Public Health, NHAP. Maintenance of the information requested on this form is authorized by the Health and Safety Code.

LIVE SCAN FORM INSTRUCTIONS

Fingerprints can be scanned at any authorized Live Scan (LS) agency. For LS agency information and locations, you can access the Internet at: https://oag.ca.gov/fingerprints/locations

Please complete the following information on the LS form:

1. Full Name of Applicant
2. Any aliases such as a maiden name (AKA's)
3. Date of birth (DOB)
4. Check applicant box for sex (SEX)
5. Place of birth (POB)
6. Social Security number (SOC)
7. California driver's license number (CDL No.)
8. Check DOJ and FBI boxes for Level of Service
9. Physical description (HT, WT, EYE Color, and Hair Color) using the appropriate abbreviations listed.

IMPORTANT:
The Live Scan form should include an ORI, Mail Code, and Misc. No. BIL – numbers. If any of these numbers are missing, please contact the Program prior to making an appointment at a LS agency! Employer section must be left blank.

Fees

The cost for processing a criminal record check is: State fee, $32.00; and Federal fee, $19.00. You must include payment with the AIT Application or Exam Application. Application **must** include one check for the application or exam and criminal record check fees.

Submit a copy of the completed live scan form to:

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

If you have any questions, please contact the Program at (916) 552-8780 or by electronic mail at **NHAP@cdph.ca.gov.**

STATE OF CALIFORNIA
BCIA 8016
(orig. 04/2001; rev. 01/2011)

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A1098
ORI (Code assigned by DOJ)

License Certification or Permit
Authorized Applicant Type

Nursing Home Administrator
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Nursing Home Administrator Program
Agency Authorized to Receive Criminal Record Information

03857
Mail Code (five-digit code assigned by DOJ)

MS 3302, P.O. Box 997416
Street Address or P.O. Box

(Leave blank)
Contact Name (mandatory for all school submissions)

Sacramento — City
CA — State
95899-7416 — ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name | Middle Initial | Suffix

Other Name (AKA or Alias) Last

First | Suffix

Date of Birth

Sex ☐ Male ☐ Female

Driver's License Number

Height | Weight | Eye Color | Hair Color

Billing Number 141823
(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number
(Other Identification Number)

Home Address Street Address or P.O. Box

City | State | ZIP Code

Your Number:
OCA Number (Agency Identifying Number)

Level of Service: ☒ DOJ ☒ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

(Leave blank)
Employer Name

(Leave blank)
Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City | State | ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency | LSID | ATI Number | Amount Collected/Billed

ORIGINAL - Live Scan Operator | SECOND COPY - Applicant | THIRD COPY (if needed) - Requesting Agency