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 cashier's check or money order (made payable to NHAP) with the appropriate fees (**AIT Program Application Fee, Application Processing Fee and Live Scan Fee**- Total $241) 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

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☐ 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.