



ADMINISTRATOR-IN-TRAINING (AIT) APPLICATION

OFFICE USE	CATEGORY	FEE
419-0161	<input type="checkbox"/> ADMINISTRATOR-IN-TRAINING REGISTRATION	\$100

YOU ARE REQUIRED TO REMIT THE FOLLOWING – PLEASE CHECKMARK ITEMS REMITTED

- APPLICATION within 15 days of starting your AIT Training. Training programs consisting of fewer than 2.5 days per week require pre-approval.
- \$100 CHECK payable to BENHA (Board Examiners of Nursing Home Administrators)
- UPDATED RESUME'
- SHORT NARRATIVE detailing your interest in becoming a nursing home administrator
- TRAINING PLAN identifying the areas of training and hours to be completed

Your application may be delayed or denied if you fail to complete all areas (including questions) on the application. Contact the board office at (971) 673-0196 if you have questions or if you require assistance.

PERSONAL INFORMATION

1. FIRST NAME MI LAST NAME

2. PREFERRED MAIL ADDRESS **Note:** All correspondence will be mailed to your preferred mailing address, which may be a matter of public record. SOCIAL SECURITY NO.* BIRTH DATE

HOME

WORK

3. HM. ADDRESS (MAILING: STREET OR PO BOX) HM. PHONE

4. HM. CITY HM. STATE HM. ZIP

5. PREFERRED EMAIL ADDRESS

FACILITY INFORMATION (TRAINING SITE)

6. NURSING HOME FACILITY POSITION

7. WK. ADDRESS (MAILING: STREET OR PO BOX) WK. PHONE

8. WK. CITY WK. STATE WK. ZIP

9. NAME OF OWNER (IF EMPLOYED BY A NURSING HOME FACILITY)

EDUCATION

10. COLLEGE / UNIVERSITY WHERE BACHELOR'S DEGREE RECEIVED CITY / STATE

11. DEGREE AREA OF STUDY GRADUATION DATE

PRECEPTOR INFORMATION

12. FIRST NAME M.I. LAST NAME

13. Is AIT related to preceptor? Yes No

If "Yes", indicate relationship:

LICENSURE & HISTORY INFORMATION

Please answer each of the following questions by putting a check (Y) in the appropriate box. You must answer each question with either a "Yes" or "No" response. All "Yes" answers must be explained on a separate SIGNED and DATED sheet of paper. Your explanation should include all relevant dates and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application.

14. Have you ever been discharged or forced to resign from a long-term care related position? Yes No
15. Are you now or within the last 5 years have you been addicted to or received treatment for any chemical substance (excluding tobacco and caffeine)? Yes No
16. Have you ever had a professional license or certification suspended, revoked or denied? Yes No
17. Have you ever voluntarily surrendered any license or certification? Yes No
18. Have you ever had limitations/restrictions placed on a professional license or certification? Yes No
19. Have you ever been disciplined or sanctioned by a professional licensing/certifying authority? Yes No
20. To your knowledge, are there any unresolved or pending actions or complaints against you with any professional licensing or certifying authority? Yes No
21. Have you ever been convicted of a crime involving:
- | | |
|---|---|
| a) Moral turpitude | a) Yes <input type="checkbox"/> No <input type="checkbox"/> |
| b) Mistreatment of patients | b) Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c) Use of any controlled substance or intoxicating liquor | c) Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d) Felony | d) Yes <input type="checkbox"/> No <input type="checkbox"/> |

AIT PROGRAM PLAN

22. **Start Date:** _____ **End Date:** _____
23. Estimated Days Per Week of Training: _____ Estimated Hours Per Day of Training: _____
24. If AIT program is less than full-time, identify other position and hrs. per week: _____
25. **INDICATE THE NUMBER OF HOURS AIT PLANS TO SPEND IN THE FOLLOWING DOMAINS OF PRACTICE**
- | | |
|--|-------------------------------|
| • Resident Care & Quality of Life _____ Hrs. | • Human Resources _____ Hrs. |
| • Leadership and Management _____ Hrs. | • Finance _____ Hrs. |
| • Physical Environment _____ Hrs. | TOTAL HOURS _____ Hrs. |

26. APPLICANT AFFIDAVIT & SIGNATURE

I declare under penalties of perjury that I have examined this application and the accompanying support documentation and to the best of my knowledge and belief, it is true, correct and complete.

SIGNATURE OF AIT

Date

27. PRECEPTOR SIGNATURE

SIGNATURE OF PRECEPTOR

Date

The preceptor should notify the NHA Board if the AIT terminates training or changes preceptors.

► Mail Documents and Payment to:
OREGON BENHA, 800 N.E. Oregon Street, Suite 407, Portland OR 97232



Please Return With Your Application

SB 786 QUESTIONNAIRE

NAME: _____

ETHNICITY (Select one):

- Caucasian
- African American
- American Indian/Alaskan Native
- Asian/Pacific Islander
- Hispanic

OTHER: _____

LANGUAGES (Other Than English)

- Bilingual? Yes No
- Spoken? Yes No
- Written? Yes No
- Fluent? Yes No

SELECT ALL THAT APPLY

- Spanish
- Vietnamese
- Chinese
- Korean
- Japanese
- Am. Sign Language
- Laotian
- Tai
- Russian
- French
- German

I do not wish to provide the above-requested information.

***PRIVACY ACT NOTIFICATION**

As part of your application for an initial or renewed professional license or registration issued by the Oregon Board of Examiners of Nursing Home Administrators (BENHA), you are required to provide your Social Security Number to this board. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305, 385, 42 USC § 405 © (2) © (I), and 42 ISC § 666 (a) (13).). Failure to provide your Social Security Number will be a basis to refuse to issue or renew the license or registration you seek.

Mandatory Uses of Licensee Social Security Numbers

BENHA is required to report your Social Security Number to the following entities:

- Division of Child Support – ORS 25.750 –25.785
- Oregon Department of Revenue – ORS 305.380 – 305.385
- United States Health Care Integrity Protection Data Bank (HIPDB) 45 CFR, Part 61, established under Section 1128E of the Social Security Act.
- National Practitioners Data Bank (NPDB) – Section (5) Medicare and Medicaid Patient and Program Protection Act of 1987.

Signature

Date