



ADMINISTRATOR-IN-TRAINING (AIT) APPLICATION

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

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

- APPLICATION must be submitted 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 Oregon Health Licensing Agency (OHLA)
- 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 OHLA at 503-378-8667 or [ohla.info@state.or.us](mailto:ohla.info@state.or.us) if you have questions.

PERSONAL INFORMATION

1. FIRST NAME MI LAST NAME

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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

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

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4. HM. CITY HM. STATE HM. ZIP

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5. PREFERRED EMAIL ADDRESS

FACILITY INFORMATION (TRAINING SITE)

6. NURSING HOME FACILITY POSITION

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

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8. WK. CITY WK. STATE WK. ZIP

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

EDUCATION

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

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11. DEGREE AREA OF STUDY GRADUATION DATE

PRECEPTOR INFORMATION

12. FIRST NAME MI LAST NAME

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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 (x) 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. | <b>TOTAL HOURS</b> | _____ 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 OHLA if the AIT terminates training or changes preceptors.

As part of your application for initial or renewed occupational, professional or recreational license, certification, or registration issued by the Oregon Health Licensing Agency, you are required to provide your Social Security number to the Oregon Health Licensing Agency. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC §405(c)(2)(C)(i), and 42 USC § 666(a)(13). Failure to provide your Social Security number will be a basis to refuse to issue or renew the license, certification, or registration you seek. This record of your Social Security number is used for child support enforcement and tax administration purposes (including identification) only, unless you authorize other uses of the number. Although a number other than your Social Security number appears on the face of the licenses, certificates, or registrations issued by the Oregon Health Licensing Agency, your Social Security number will remain on file with the Oregon Health Licensing Agency. I have examined this application and certify that it is true, correct, and complete. I understand that knowingly making a false statement on this application will be cause for denial, suspension, or revocation of certification. I have enclosed the required fees and documentation. I understand my application may be subject to a criminal background check. I authorize the use of my Social Security number for that purpose. If registered to practice in Oregon, I will comply with the laws and rules adopted by the Oregon Health Licensing Agency.

**Applicant Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

ORS 181.534, 676.608, and 676.612 authorize the Oregon Health Licensing Agency to conduct criminal background checks and the agency requests that you voluntarily provide your Social Security Number for this purpose. Failure to provide your Social Security Number for this purpose will not be used as a basis to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your Social Security Number by the Oregon Health Licensing Agency for this purpose, it may be used only for criminal records checks. I hereby voluntarily consent to disclose my Social Security Number to the Oregon Health Licensing Agency for criminal background checks.

**Applicant Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Mandatory Uses of Licensee Social Security Numbers**

OHLA 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.

► **Mail documents and payment to: OHLA, 700 Summer St. NE, Suite 320, Salem, OR 97301-1287**

**Senate Bill 786 QUESTIONNAIRE**

Answering the following is voluntary. I do not wish to provide the requested information.

**NAME:** \_\_\_\_\_

**ETHNICITY (Select one):**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Caucasian              | <input type="checkbox"/> African American | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Hispanic         |   |

**OTHER:** \_\_\_\_\_

**LANGUAGES (Other Than English)**

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

**SELECT ALL THAT APPLY**

- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> Spanish           | <input type="checkbox"/> Laotian |
| <input type="checkbox"/> Vietnamese        | <input type="checkbox"/> Tai     |
| <input type="checkbox"/> Chinese           | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Korean            | <input type="checkbox"/> French  |
| <input type="checkbox"/> Japanese          | <input type="checkbox"/> German  |
| <input type="checkbox"/> Am. Sign Language |                                  |