Oregon Board of Examiners of Nursing Home Administrators
800 NE Oregon, Suite 407
Portland, OR 97232-2162
Phone: 971-673-0196 FAX: 971-673-0226
Email: NHABD.Info@state.or.us

ADMINISTRATOR-IN-TRAINING
PRECEPTOR / PROGRAM CHANGE REPORT

- Trainees and Preceptors are required to notify the Board of a change in preceptor or facility (training site); program suspension and resumption; and program termination.
- Complete and remit this form via mail, fax, or email to the address listed above within 15 days of the change that you are reporting. Include your revised training plan if there are any significant changes to your program.

CHANGE TO REPORT (Check all that apply)

☐ **Preceptor Change** ☐ **Facility Change** ☐ **Program Interrupted** ☐ **Program Resumed** ☐ **Program Terminated**

PERSONAL INFORMATION

1. FIRST NAME | MI | LAST NAME
2. HM. ADDRESS (MAILING: STREET OR PO BOX) | HM. PHONE
3. HM. CITY | HM. STATE | HM. ZIP
4. PREFERRRED EMAIL ADDRESS

NEW FACILITY INFORMATION (TRAINING SITE)

5. NURSING HOME FACILITY
6. WK. ADDRESS (MAILING: STREET OR PO BOX) | WK. PHONE
7. WK. CITY | WK. STATE | WK. ZIP

NEW PRECEPTOR INFORMATION

8. FIRST NAME | M.I. | LAST NAME
9. Is AIT related to preceptor? ☐ Yes ☐ No If **"Yes"**, indicate relationship:

PROGRAM INTERRUPTION / RESUMPTION INFORMATIOIN

10. Date Program **Interrupted/Ended**: Date Program **Resumed**:
11. **If Interrupted**, Estimated Resumption Date: **If Resumed**, Estimated End Date:
12. **If Resumed**, Estimated Days and Hours Per Week of Training: Days Hours
13. **If Resumed** less than full-time, identify other position held in the facility::

APPLICANT AFFIDAVIT & SIGNATURE

I declare the foregoing information to the best of my knowledge and belief to be true, correct, and complete.

14. ***SIGNATURE OF AIT*** **Date**

PRECEPTOR SIGNATURE

15. ***SIGNATURE OF PRECEPTOR*** **Date**