Oregon Health Authority

HEALTH LICENSING OFFICE
Long Term Care Administrators Board

1430 Tandem Ave. NE, Suite 180, Salem, OR 97301-2192
Phone: 503-378-8667 | Fax: 503-370-9004
www.healthoregon.org/hlo | Email: hlo.info@state.or.us

Print Form

NURSING HOME ADMINISTRATOR AIT REGISTRATION APPLICATION

1. Applicant Information

APPLICANT NAME: LAST	FIRST	MIDDLE INTIAL

RESIDENTIAL PHYSICAL ADDRESS **(REQUIRED)**		
CITY	STATE	ZIP
MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)		
CITY	STATE	ZIP

PHONE: ☐ HOME ☐ CELL	BUSINESS TELEPHONE	EMAIL
GENDER ☐ Female ☐ Male	BIRTHDATE	SOCIAL SECURITY NUMBER (**REQUIRED**)

- Have you ever been known under any other name?
  ☐ **No** ☐ **Yes** – If yes, list full name(s):
- Do you hold or have you previously held licensure, certification or registration with the Health Licensing Office or any other state? ☐ **No** ☐ **Yes** - If yes, please list information below.

State:	Lic./Cert./Reg.#	Expiration:
State:	Lic./Cert./Reg.#	Expiration:
State:	Lic./Cert./Reg.#	Expiration:

2. ***(Complete This Section Only If Submitting Payment By Mail)***

Payment of Required Fees: Application Fee = $100

Please check one: ☐ Cash ☐ Check ☐ Money order ☐ Purchase order ☐ Credit card (see below)

Type of Credit Card: ☐ Visa ☐ MasterCard ☐ Discover (Cardholder must either be the applicant or be present at the time application is submitted) **Do Not Fax or Email Credit Card Information**

Name on card: _____

Card number: _____ Exp: _____ Authorized amount: $_____

Cardholder signature: _____

(Do not write in this section – Official use only)

License #: _____ **Initials** _____ **OTC** ☐ **Verified ID** ☐ **Type:** _____

☐ **Approval Code/CK#** _____

Return All Pages Of This Application And Keep A Copy For Your Records

3. Individual Records Questions: Please accurately answer all of the questions below. The Office may review your information through the Law Enforcement Data System, other governmental agencies, and private vendors to confirm the accuracy of the information. Any misrepresentation or failure to disclose information may result in disciplinary action.

- Are you now, or have you ever been, the subject of any active or inactive disciplinary action or voluntary resignation of a professional license, certificate, registration or permit imposed by a licensing or regulatory authority in this or any other state? Disciplinary action includes, but is not limited to, probation, suspension, civil penalty, or any other sanction limiting, in any way, a license, certificate, registration or permit. ☐ **Yes** ☐ **No** If yes, please explain **(attach additional pages if necessary)**:

- Have you ever been convicted of a misdemeanor or felony? ☐ **Yes** ☐ **No**

  If yes, please list **all** convictions, including the charges as stated in the court documents and year convicted **(attach additional pages if necessary).**

	Year Convicted

- As of today are you on probation or parole? ☐ **Yes** ☐ **No** If yes, you **must** provide a letter of release from your probation or parole officer authorizing you to obtain an authorization to practice. If you are on bench probation, or probation with the court, you must provide documentation of your conditions of the probation.

As part of your application for initial or renewed occupational or professional license, certification, or registration issued by the Health Licensing Office, you are required to provide your Social Security number (SSN) to the Office. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC §405(c)(2)(C)(i), 42 USC § 666(a)(13), and 41 CFR 61.7. Failure to provide your SSN will be a basis to refuse to issue or renew the license, certification, or registration you seek. This record of your SSN is used for child support enforcement and tax administration purposes (including identification). The HLO will use your SSN for these purposes only, unless you authorize other uses of the number. Your SSN will remain on file with the Office.

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 my license, certification or registration. I have enclosed the required fees and documentation.

Applicant Signature:	**Date:**

ORS 181.534, 670.280, 676.608, and 676.612 authorize the Health Licensing Office to conduct criminal background checks and the office requests that you voluntarily provide your Social Security number for this purpose. I understand my application may be subject to a criminal background check.

Before issuing a default final order, the Health Licensing Office must determine the military status of a Respondent, under 50 USC App § 521(b) (Supp. 2005). Your Social Security Number may be used in order to verify your military status (or lack thereof).

If any disciplinary action is taken against your license, certification, or registration, your Social Security Number may be reported to the National Practitioner Data Bank (NPDB) under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986 (Title IV); Section 1921 of the Social Security Act (Section 1921); Section 1128E of the Social Security Act (Section 1128E); and their implementing regulations found at 45 CFR Part 60.

I hereby voluntarily consent to disclose my Social Security number to the HLO for criminal background checks, verification of military status, and reports to the National Practitioner Data Bank (NPDB). Failure to provide your Social Security number for these purposes 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 HLO for these purposes, it may be used only for these purposes.

Applicant Signature:	**Date:**

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4. Race / Ethnicity – Voluntary Question

The State of Oregon has an Affirmative Action policy. If you choose to provide your race/ethnicity information below, it will help us evaluate the effectiveness of our affirmative action programs. This information will also be used in the aggregate (i.e. as a whole, not individually) for research and statistical purposes. It will not be tied specifically or directly to your licensing eligibility or qualifications.

Ethnic Background (check only one)

- ☐ **American Indian or Alaska Native (I)** (Non-Hispanic or Latino): A person having origins in any of the original peoples of North and South American (including central America), and who maintain a tribal affiliation or community attachment.
- ☐ **Asian (A)** (Non-Hispanic or Latino): A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- ☐ **Black or African American (B)** (Non-Hispanic or Latino): A person having origins in any of the black racial groups of Africa.
- ☐ **Hispanic or Latino (H)**: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin regardless of race.
- ☐ **Native Hawaiian or other Pacific Islander (P)** (Non-Hispanic or Latino): A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **White (W)** (Non-Hispanic or Latino): All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
- ☐ **Two or more races (T)** (Non-Hispanic or Latino): Persons who identify with two or more racial categories named above.

5. Preceptor and Facility (Training Site) Information

PRECEPTOR NAME: LAST	FIRST	MI

PRECEPTOR LICENSE #	LICENSE EXPIRATION DATE:	PHONE:

FACILITY (TRAINING SITE) NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:

APPLICATION REQUIREMENTS FOR NURSING HOME ADMINISTRATOR AIT REGISTRATION

Applicant Must:

- ☐ Meet the requirements of Chapter 331, Division 30 of Oregon Administrative Rule;
- ☐ Submit this completed application accompanied by payment of required fees; **and**
- ☐ Submit **two** forms of acceptable identification **both of which must include applicant's current legal name**. Front and back of legible (clear) photocopies if submitted by mail. **At least one form of identification provided to the HLO must be photographic**. Acceptable identification options can be found under Chapter 331, Division 30 of Oregon Administrative Rule;

NOTE: The applicant is responsible for payment of fees assessed by the organization when obtaining required official documentation.

(SEE AIT PROGRAM INFORMATION ON NEXT PAGE)

AIT PROGRAM INFORMATION

Oregon Administrative Rule 853-030-0040
Nursing Home AIT Program

(1) The AIT program consists of 960 hours of Preceptor-supervised training.

(2) An AIT program applicant must be registered before beginning the AIT program.

(3) An AIT must complete the AIT program in no less than six months and no more than two years after the Office approves the application. An AIT failing to complete the program within two years after the approval date, the applicant must reapply and, if accepted, must begin the program again.

(4) An AIT Program applicant who is in good standing with the Office, with no current or pending Office disciplinary action and no fines, fees, or civil penalties currently owing to the Office, may apply for a waiver of 80 hours of the AIT Program pertaining to resident care and quality of life if the applicant demonstrates to the satisfaction of the Health Licensing Office that:

(a) the applicant holds a current credential as a certified nursing assistant (CNA) with no current or pending disciplinary action related to that credential; or

(b) the applicant holds a certificate of completion from a CNA program and the certificate was issued within two years of the date on which the Office receives the applicant's AIT Program application.

(5) An AIT Program applicant who is in good standing with the Office, with no current or pending Office disciplinary action and no fines, fees, or civil penalties currently owing to the Office, may apply for a waiver of 160 hours of the AIT Program pertaining to resident care and quality of life if the applicant demonstrates to the satisfaction of the Health Licensing Office that:

(a) The applicant holds a current credential as a LPN or RN, with no current or pending disciplinary action related to that credential;

(b) The applicant is currently working as a LPN or RN in a long-term care facility; and

(c) the applicant has been working as a LPN or RN in a long-term care facility or long term care facilities for at least three of the last five years immediately preceding the date on which the Office receives the applicant's AIT Program application.

(6) An AIT Program applicant who is in good standing with the Office, with no current or pending Office disciplinary action and no fines, fees, or civil penalties currently owing to the Office, may apply for a waiver of 450 AIT Program hours if the applicant demonstrates to the satisfaction of the Health Licensing Office that:

(a) The applicant has been the acting administrator of a residential care facility for at least three of the last five years immediately preceding the date on which the Office receives the AIT's application; and

(b) The facility was, or the facilities were, not subject to conditions imposed by the Department of Human Services throughout the time that the applicant was acting administrator.

(7) An AIT may apply for a waiver under section (4), (5) or (6) of this rule, but not more than one. An applicant applying for a waiver under section (4)(a) or (5) of this rule must submit an affidavit of licensure pursuant to OAR 331-030-0040.

(8) An AIT must notify the Office within 10 business days if they are no longer supervised by a Preceptor.

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AIT REQUEST FOR WAIVER OF PARTIAL TRAINING HOURS

*****Only complete this form and submit if you are requesting a waiver of hours. If you are not requesting a waiver of hours, do not complete or submit this page of the form.**

I, _____ am requesting the following training be waived:
(Please Print Full Name)

I understand hours towards my training, in resident care and quality of life, **may** be waived based on the following criteria (**choose only one option as you are not allowed to use more than one option to waive hours**):

☐ **CNA -** 80 hours

To qualify, applicant must submit:

- An affidavit of licensure demonstrating proof of current CNA certification with no current or pending disciplinary actions and with no fines, fees, or civil penalties currently owing to the Health Licensing Office (HLO). The affidavit must be sent directly to the HLO from the licensing entity; ***or***
- A certificate of completion from a CNA program and the certificate was issued within two years of the date on which the HLO receives the applicant's AIT Program application.

NOTE: The applicant is responsible for payment of fees assessed by the organization when obtaining required official documentation.

OR

☐ **RN or LPN -** 160 hours

To qualify, applicant must submit:

- An affidavit of licensure demonstrating proof of current LPN or RN licensure with no current or pending disciplinary actions and with no fines, fees, or civil penalties currently owing to the Health Licensing Office (HLO). The affidavit must be sent directly to the HLO from the licensing entity; ***and***
- Proof of currently working as a LPN or RN in a long-term care facility; ***and***
- Proof of having worked as a LPN or RN in a long-term care facility for at least three of the last five years immediately preceding the date on which the HLO receives the applicant's AIT Program application.

NOTE: The applicant is responsible for payment of fees assessed by the organization when obtaining required official documentation.

OR

☐ **Acting Administrator of a Residential Care Facility -** 450 hours

To qualify, applicant must submit:

- Proof that the applicant has been the acting administrator of a residential care facility for at least three of the last five years immediately preceding the date on which the HLO receives the applicant's AIT Program application; ***and***
- Proof that the facility was, or the facilities were, not subject to conditions imposed by the Department of Human Services throughout the time that the applicant was the acting administrator.

NOTE: The applicant is responsible for payment of fees assessed by the organization when obtaining required official documentation.

This request form must be submitted with your AIT application.

Signature: _____ **Date:** _____

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