



HEALTH LICENSING OFFICE Long Term Care Administrators Board

1430 Tandem Ave. NE, Suite 180, Salem, OR 97301-2192
Phone: (503) 378-8667 | Web: www.oregon.gov/oha/ph/hlo

For Office Use Only		
Applicant #:	NHA-IT #:	Staff Initials:

Nursing Home Administrator AIT Registration Application

Applicant Information				
LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
BIRTHDATE:	GENDER:	<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE	<input type="checkbox"/> NONBINARY / OTHER
RESIDENTIAL PHYSICAL ADDRESS (REQUIRED):				
CITY:		STATE:	ZIP:	
MAILING ADDRESS (IF DIFFERENT FROM ABOVE):				
CITY:		STATE:	ZIP:	
BUSINESS PHONE:		PERSONAL PHONE:		
EMAIL (REQUIRED):		SOCIAL SECURITY # (REQUIRED):		
Have you ever been known under any other legal name? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list all previous full (legal) names below:				
Previous legal name(s):				
Do you hold or have you previously held licensure, certification or registration with the Health Licensing Office or any other state? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please list information below (add additional blank page if necessary):				
State:	Lic./Cert./Reg. #:		Expiration:	
Payment Information (complete this section only if submitting payment by mail)				
Required Fees: *The AIT registration fee is non-refundable. DO NOT MAIL CASH.				
*AIT Registration Fee = \$100				
Select one payment option:	<input type="checkbox"/> Check	<input type="checkbox"/> Credit Card (see below)	<input type="checkbox"/> Money Order	<input type="checkbox"/> Purchase Order
Type of credit card (American Express card is not accepted):	<input type="checkbox"/> Visa	<input type="checkbox"/> Mastercard	<input type="checkbox"/> Discover	
Note: The credit card holder must either be the applicant or be present at the time this application is submitted.				
Name on credit card:				
Card number:		Exp date:	Authorized amount: \$	
Cardholder signature:				
(Do not write in the following section – Office use only)				
<input type="checkbox"/> OTC <input type="checkbox"/> Verified ID <input type="checkbox"/> Verified Out-of-state Licensure Type of ID: _____ Appr Code/CK # _____ Staff Initials _____				
Payment method: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> MO <input type="checkbox"/> PO <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover AMOUNT: _____ INITIALS: _____ <input type="checkbox"/> Approval code/CK#: _____	Payment method: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> MO <input type="checkbox"/> PO <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover AMOUNT: _____ INITIALS: _____ <input type="checkbox"/> Approval code/CK#: _____	Payment method: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> MO <input type="checkbox"/> PO <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover AMOUNT: _____ INITIALS: _____ <input type="checkbox"/> Approval code/CK#: _____		

Individual Records Questions	
<p>Please accurately answer all the questions below. The Health Licensing Office (HLO) 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.</p>	
<p>1. Do you have any pending or completed investigations or any disciplinary actions taken against you by any licensing or regulatory authority? 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. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach an additional page(s) and provide an explanation.</p>	
<p>2. Have you ever been convicted of a misdemeanor or felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list all convictions, including the charges and year convicted (attach additional pages if necessary).</p>	<p>Year Convicted</p>
<p>3. As of today, are you on probation or parole? <input type="checkbox"/> Yes <input type="checkbox"/> 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.</p>	
Mandatory Social Security Number Disclosure and Use	
<p>You are required to provide your Social Security number (SSN) to the HLO as part of your application for initial or renewed occupational or professional license, certification, or registration issued by HLO pursuant to ORS 25.785, ORS 305.385, 42 USC § 666(a)(13) and 42 USC §405(c)(2)(C)(i). Failure to provide your SSN will be a basis to refuse to issue or renew the license, certification, or registration you seek. HLO is authorized by law to use your SSN for child support enforcement and tax administration purposes only. HLO will only use your SSN for these purposes unless you authorize other uses of your SSN as discussed below. Your SSN will remain on file with HLO. If you have never been assigned an SSN, please refer to the section below titled Request for Exemption from Social Security Number Disclosure and Attestation.</p>	
Voluntary SSN Disclosure and Use - Criminal Background Checks and Military Status Verification	
<p>The HLO is authorized to conduct criminal background checks pursuant to ORS 181A.195, 676.608, and 676.612. The HLO requests that you voluntarily provide your SSN for this purpose. Pursuant to 50 USC § 3931, the HLO must determine the military status (or lack thereof) of a respondent before issuing a default final order. The HLO requests that you voluntarily provide your SSN for this purpose. Failure to provide your SSN for these purposes will not be used to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your SSN by the HLO for these purposes, it may be used only for these purposes.</p>	
<p>4. I voluntarily consent to disclose my SSN to the HLO for criminal background checks and military status verification. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
Voluntary Social Security Number Disclosure and Use – Reporting to the National Practitioner Data Bank (NPDB)	
<p>For any HLO license, certification, or registration that reports to the National Practitioner Data Bank (NPDB), if any disciplinary action is taken against you, HLO requests that you voluntarily provide your SSN so that HLO may report it to the NPDB under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986; Section 1921 of the Social Security Act; Section 1128E of the Social Security Act; and their implementing regulations found at 45 CFR Part 60. Failure to provide your SSN for this purpose will not be used to deny your application, or to deny you any right, benefit or privilege provided by law. If you consent to the use of your SSN by the HLO for this purpose, it may be used only for this purpose.</p>	
<p>5. I voluntarily consent to disclose my SSN to the HLO to report to the NPDB. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
Request for Exemption from Social Security Number Disclosure and Attestation	
<p>6. If you do not have a Social Security number (SSN) you may request an exemption from the SSN requirement. To receive the exemption, you must attest and certify that you have never been assigned an SSN and if you are ever assigned an SSN, you will report it to the HLO within 30 days.</p> <p style="text-align: center;">*DO NOT SIGN BELOW IF YOU HAVE A SOCIAL SECURITY NUMBER*</p> <p>By signing below, I attest and certify that I have never been assigned an SSN and agree that if an SSN is assigned to me, I will report it to the HLO within 30 days.</p>	
<p>Applicant Signature:</p>	<p>Date:</p>
Certification of Information Provided	
<p>7. I have examined this application and supporting documentation and certify by my signature below that it is true, correct, and complete. I understand that providing false information or 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.</p>	
<p>Applicant Signature:</p>	<p>Date:</p>

Affirmative Action – Voluntary Question

The State of Oregon has an Affirmative Action (AA) Policy. If you choose to provide the optional information below, it will help to evaluate the effectiveness of our AA 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 information.

Which of the following describes your racial or ethnic identity? Please check all that apply.

American Indian and Alaska Native

- ☐ American Indian
☐ Alaska Native
☐ Canadian Inuit / Metis / First Nation
☐ Indigenous Mexican / Central American / South America

Asian

- ☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Communities of Myanmar
☐ Filipino / Filipina
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ South Asian
☐ Vietnamese
☐ Other Asian

Black and African American

- ☐ African American
☐ Afro-Caribbean
☐ Ethiopian
☐ Somali
☐ Other African (Black)
☐ Other Black

Hispanic and Latino/Latina/Latinx

- ☐ Central American
☐ Mexican
☐ South American
☐ Other Hispanic or Latino/Latina/Latinx

Middle Eastern / North African

- ☐ Middle Eastern
☐ North African

Native Hawaiian and Pacific Islander

- ☐ Chamoru/Chamorro
☐ Guamanian
☐ Marshallese / Micronesian / Palauan / Tongan
☐ Communities of the Micronesian Region
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander

White

- ☐ Eastern European
☐ Slavic
☐ Western European
☐ Other White

Other Categories

- ☐ Other: _____
☐ Unknown
☐ Decline to answer

If you checked more than one race or ethnicity above, is there **one** you think of as your primary racial or ethnic identity?

- ☐ Yes, please list: _____
☐ I do not have just one primary racial or ethnic identity
☐ No, I identify as Bi-racial or Multi-racial
☐ Not applicable, I only checked one category above
☐ Unknown
☐ Decline to answer

Application Requirements

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

Applicant must:

_____	Meet the requirements of Oregon Administrative Rule, Chapter 331, Division 30 .
_____	<p>Submit this completed application, accompanied by payment of the required fees.</p> <p>*AIT Registration fee = \$100 (see payment information on first page).</p> <p>*THE REGISTRATION FEE IS NON-REFUNDABLE.</p> <p>DO NOT SEND CASH THROUGH THE MAIL.</p>
_____	<p>Submit two forms of original identification issued by a government agency. Acceptable identification options can be found under Chapter 331, Division 30 of Oregon Administrative Rule.</p> <p>ID requirements are as follows:</p> <ul style="list-style-type: none"> • The two forms of ID must be issued by a government agency. • Both the ID's must include the applicant's current legal name. • At least one form of ID provided must be photographic. • We do not accept student ID cards, department store or warehouse cards, debit cards, etc. If you have a question about whether a particular ID type is acceptable, please call (503) 378-8667, to verify. • If submitting photocopies of your ID by mail, legible (clear) front and back copies must be submitted. Submit the copies on a full-sized piece(s) of copy paper, do not cut the ID images out. <p>If you do not meet all of the ID requirements above, you run the risk of your application process being delayed.</p>
_____	Have you answered questions 1 through 5 on page two of this application? If you fail to answer each of the questions, this application may be returned to you and potentially cause a delay in processing.
_____	If you <u>do not</u> have a social security number (SSN), have you signed and dated section 6 on page two of this application? If you do have an SSN that you have provided on page one, do not complete this section.
_____	Have you signed and dated section 7 on page two of this application? If you fail to sign and date this section, your application will be returned to you and will cause a delay in processing.
_____	Have you completed the Preceptor / Training Facility Information section on page five of this application?
_____	Have you completed the payment information section of this application and enclosed payment or provided credit card information?
_____	<p>Keep a copy of your application and supporting documents before submitting everything to the Health Licensing Office (HLO).</p> <p>You have two options to submit your application (submit your application only once):</p> <ol style="list-style-type: none"> 1. Mail the application. Enclose payment or provide credit card information, enclose copies of your identification, and enclose copies of your required supporting documents to the HLO. The address is listed at the top of this application. 2. Bring the application to the HLO. Bring the completed application, payment for fees, two forms of your original identification, and required supporting documents to the HLO. The address is listed at the top of this application.

Preceptor / Training Facility Information		
PRECEPTOR LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
PRECEPTOR LICENSE NUMBER:	LICENSE EXPIRATION DATE:	
FACILITY / TRAINING SITE NAME:		
FACILITY / TRAINING SITE ADDRESS:		
CITY:	STATE:	ZIP:
PRECEPTOR PHONE NUMBER:	PRECEPTOR EMAIL:	

AIT Program Information
Oregon Administrative Rule 853-030-0040
<p>Nursing Home AIT Program</p> <p>(1) The AIT program consists of 960 hours of Preceptor-supervised training.</p> <p>(2) An AIT program applicant must be registered before beginning the AIT program.</p> <p>(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.</p> <p>(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:</p> <p>(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</p> <p>(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.</p> <p>(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:</p> <p>(a) The applicant holds a current credential as an LPN or RN, with no current or pending disciplinary action related to that credential;</p> <p>(b) The applicant is currently working as an LPN or RN in a long-term care facility; and</p> <p>(c) the applicant has been working as an 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.</p> <p>(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:</p> <p>(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</p> <p>(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.</p> <p>(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.</p> <p>(8) An AIT must notify the Office within 10 business days if they are no longer supervised by a Preceptor.</p>

AIT Request for Waiver of Partial Training Hours

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

*****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.

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.

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.

Administrator-In-Training Verification Acknowledgement

By signing below, I attest and certify that I have received the certification, licensure and training as specified above.

Signature:

Date: