



**HEALTH LICENSING OFFICE**  
**Nursing Home Administrators Board**

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

**NURSING HOME ADMINISTRATOR AIT REGISTRATION APPLICATION**

**1. Applicant Information**

APPLICANT NAME: LAST	FIRST	MIDDLE INITIAL
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RESIDENTIAL PHYSICAL ADDRESS (REQUIRED)

CITY	STATE	ZIP
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MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)

CITY	STATE	ZIP
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PHONE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL	BUSINESS TELEPHONE	EMAIL
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GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male	BIRTHDATE	SOCIAL SECURITY NUMBER (REQUIRED)
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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:
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State:	Lic./Cert./Reg.#	Expiration:
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State:	Lic./Cert./Reg.#	Expiration:
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**2. \*\*\* (Complete This Section Only If Submitting Payment By Mail) \*\*\***

**Method Of Payment For 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# \_\_\_\_\_

3. 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:

**4. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list <b>all</b> convictions, including the charges as stated in the court documents and year convicted ( <b>attach additional pages if necessary</b> ).	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.

<b>Applicant Signature:</b>	<b>Date:</b>
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### Individual Records Questions *(continued)*

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 federal Health Care Integrity and Protection 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 Health Care Integrity and Protection Data Bank. 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:**

### 5. Affirmative Action – Voluntary Question

The State of Oregon has an Affirmative Action Policy. If you choose to provide this information, 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 information.

#### Ethnic Background *(check only one)*

- (A) **Asian or Pacific Islander:** Persons having origins in any of the peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.
- (B) **African American *(not of Hispanic origin)*:** Persons having origins in any of the Black racial groups of Africa.
- (H) **Hispanic:** Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish cultures or origin, regardless of race.
- (I) **American Indian or Alaskan Native:** Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.
- (W) **Caucasian *(not of Hispanic origin)*:** Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

#### **REQUIREMENTS FOR NURSING HOME ADMINISTRATOR AIT REGISTRATION APPLICATION**

Applicant Must:

- Meet the requirements of OAR 331 division 30;
- Submit a completed application form prescribed by the Agency, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of the required application fees = **\$100** *(see method of payment section above)*; and
- Submit **two** forms of acceptable identification as listed in OAR 331-030-0000(8), **both of which must include applicant's current legal name**. Front and back of legible (clear) photocopies if submitted by mail. **Pursuant to OAR 331-030-0000(10) at least one form of identification must be photographic; driver license, state ID card, passport or military ID card.**

**(SEE AIT PROGRAM INFORMATION ON NEXT PAGE)**

## AIT PROGRAM INFORMATION

### **(OAR) 853-030-0040**

The AIT program consists of 960 hours of training under the supervision of a preceptor. The training program documentation can be reviewed at <http://www.oregon.gov/OHA/hlo/Pages/Board-Nursing-Home-Administrators.aspx>

- (1) An AIT program applicant must apply for and be granted registration pursuant to OAR 853-030-0020 prior to beginning the AIT program.
- (2) An AIT registered after January 1, 2012:
  - (a) Must complete the AIT program in no less than six months and no more than two years after beginning the program. An AIT failing to complete the program within two years after beginning the program must reapply and, if accepted, must begin the program again;
  - (b) May apply for a waiver of up to 80 hours of the AIT program pertaining to resident care and quality of life if the AIT submits *(see waiver request form attached)*:
    - (A) Proof of current CNA certification with no current or pending disciplinary actions and with no fines, fees, or civil penalties currently owing. Applicants must submit an affidavit of licensure pursuant to OAR 331-030-0040; or
    - (B) A certificate of completion from a CNA program within the last two years preceding the date of registration application;
  - (c) May apply for a waiver of up to 160 hours of the AIT program pertaining to resident care and quality of life if the AIT:
    - (A) Submits proof of current licensure as a LPN or RN in a long-term care facility, with no current or pending disciplinary actions and with no fines, fees, or civil penalties currently owing; and
    - (B) Has three years of experience within the last five years as a LPN or RN in a long-term care facility. Applicants must submit an affidavit of licensure pursuant to OAR 331-030-0040; and
  - (d) May apply for a waiver under subsection (b) or (c) of this rule, but not both.
- (3) A registered preceptor must provide the AIT a minimum of four (4) hours per month of in-person consultation regarding the strengths, progress, and competency development needs of the AIT, and to suggest methods of improvement. In-person consultation must be documented on a form prescribed by the agency.
- (4) A registered preceptor must:
  - (a) Train only one AIT at any one time;
  - (b) Sign the Certificate of Training completion forms;
- (5) Both the AIT and preceptor registrants must notify the agency of any discontinuation of, change or interruptions in the AIT program.
- (6) An AIT registered prior to January 1, 2012, may complete training under that AIT's currently approved program. The AIT must complete the AIT program in no less than six months and no more than two years after beginning the program. An AIT failing to complete the program within two years after beginning the program must reapply and, if accepted, must begin the program pursuant to OAR 853-030-0040(2);
- (7) Neither AIT registration nor acceptance into an AIT program authorizes an AIT registrant to practice or offer to practice as a nursing home administrator or to use the title of or abbreviations for Nursing Home Administrator. An AIT registrant engaging in such conduct may be disqualified from all or part of the training program. See ORS 678.720(1).



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**ADMINISTRATOR-IN-TRAINING (AIT)**  
**CERTIFICATE OF TRAINING**

*This form must be completed by the preceptor and signed by both the preceptor and the AIT, and must be submitted with the AIT registration application.*

**AIT Applicant Information**

APPLICANT NAME: LAST FIRST MIDDLE INTIAL

**Training Facility Information**

NAME OF FACILITY:

TRAINING FACILITY PYHSICAL ADDRESS: **(REQUIRED)**

CITY: STATE: ZIP: FACILITY PHONE NUMBER:

**Registered Preceptor Information**

PRECEPTOR NAME: LAST FIRST MIDDLE INTIAL

PHONE:  HOME  CELL BUSINESS TELEPHONE: EMAIL:

Preceptor's Oregon Nursing Home Administrator license number:

**Training Information**

This certification covers the training dates from: to:

AIT listed above worked an average of \_\_\_\_\_ days per week, over a period of \_\_\_\_\_ weeks.

**Training Hours**

Domain	Hours Required	Hours Received
Resident Care and Quality of Life	336	
Human Resources	144	
Finance	144	
Physical Environment	96	
Leadership and Management	240	
<b>Total</b>	<b>960</b>	

**By signing below**, I certify that the AIT listed above, under my supervision as a preceptor registered with the Oregon NHAB, has received the training as specified within this Certification of Training and has completed the hours within each domain as indicated above.

\_\_\_\_\_  
Signature of AIT

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Preceptor

\_\_\_\_\_  
Date

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**AIT REQUEST FOR WAIVER OF PARTIAL TRAINING HOURS**

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 one only**);

**RN or LPN - 160 hours**

To qualify, applicant must submit:

- An affidavit of licensure pursuant to OAR 331-030-0040, demonstrating proof of current licensure as an LPN or RN, with no current or pending disciplinary actions and with no fines, fees, or civil penalties currently owing. The affidavit must be sent directly to the HLO from the licensing entity; and
- Proof of having three years of experience within the last five years as a LPN or RN in a long-term care facility.

**OR**

**CNA - 80 hours;**

To qualify, applicant must submit:

- An affidavit of licensure pursuant to OAR 331-030-0040, demonstrating proof of current CNA certification with no current or pending disciplinary actions and with no fines, fees, or civil penalties currently owing. The affidavit must be sent directly to the HLO from the licensing entity; or
- A certificate of completion from a CNA program within the last two years preceding the date of registration application:

This request form must be submitted with your AIT application.

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