

**STATE OF NEVADA**  
**ADMINISTRATOR IN TRAINING (AIT)**  
**REQUIREMENTS**

The State of Nevada requires that all Applicants for Nursing Facility Administrator must have fulfilled 1,000 hours of Administrator-In-Training at a Board Approved Program under the direction of an approved Preceptor in not less than 26 weeks.

The Preceptor is a licensed Nursing Home Administrator who also helps the trainee prepare for the National Exam.

The AIT Training is required to address the five (5) Domains of Practice as established by the National Association of Boards of Examiners of Long Term Care Administrators (NAB) as listed below:

1. Resident Care and Quality of Life
2. Personnel Management
3. Financial Management
4. Physical Environment and Atmosphere Management
5. Leadership and Management

A suggested time frame for each Domain follows:

**1. Resident Care and Quality of Life:**

<u>Department</u>	<u>Recommended Time Frame</u>
(1) Nursing	4 weeks
(2) Medical/Patient Records	1 week
(3) Dietary	2 weeks
(4) Rehab Services	1 week
(5) Activity/Social Services	1 week

**2. Personnel Management:**

(1) Human Resources	1 week
(2) Payroll/Benefits	2 weeks
(3) Staff Development	2 weeks

**3. Financial Management:**

(1) Business Office	2 weeks
(2) Central Supply Services	1 week

**4. Physical Environment and Atmosphere Management:**

- |     |                         |        |
|-----|-------------------------|--------|
| (1) | Environment Maintenance | 1 week |
| (2) | Housekeeping            | 1 week |
| (3) | Laundry                 | 1 week |

**5. Leadership and Management:**

- |     |                                 |         |
|-----|---------------------------------|---------|
| (1) | Administration                  | 5 weeks |
| (2) | Additional Clinical Experiences | 1 week  |

The actual time frames for the Departmental rotations for each AIT will be determined by the Preceptor.

The sequencing and length of these rotations should be based on factors such as the AIT's previous work and academic experience, as well as licensure surveys. It is the responsibility of the AIT and Preceptor to ensure that all rotations have taken place.

NEVADA BOARD OF EXAMINERS  
FOR LONG TERM CARE ADMINISTRATORS

APPLICATION FOR PRECEPTOR

Date: \_\_\_\_\_ 20\_\_\_\_\_

Administrator's Name: \_\_\_\_\_ \* License No. \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

Facility Telephone: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Facility Email: \_\_\_\_\_

Years of Experience as a Nursing Home Administrator: \_\_\_\_\_

\_\_\_\_\_  
*Administrator's Signature* Date: \_\_\_\_\_

Reviewed by BELTCA \_\_\_\_\_ Date: \_\_\_\_\_

Accepted: \_\_\_\_\_ Date: \_\_\_\_\_

Preceptors must be licensed for a minimum of 2 years and licenses must be verified by BELTCA. Applicants with out of state licenses must have their licenses verified by submitting a License Verification Form to the State Agency that issued the license. The Verification Form is available on our Website.

**NEVADA BOARD OF EXAMINERS  
FOR LONG TERM CARE ADMINISTRATORS  
3157 North Rainbow Boulevard, #313  
Las Vegas, Nevada 89108  
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Fax: 702-486-5439  
E-mail: [beltea@beltea.nv.gov](mailto:beltea@beltea.nv.gov)  
Website: [beltea.Nevada.gov](http://beltea.Nevada.gov)**

**PRECEPTOR/ADMINISTRATOR-IN-TRAINING AGREEMENT**

Date: \_\_\_\_\_ 20\_\_\_\_

I, \_\_\_\_\_, agree to the responsibilities of Preceptor

For: \_\_\_\_\_ at

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ *City*

\_\_\_\_\_ *State*

\_\_\_\_\_ *Zip*

Commencing: \_\_\_\_\_ 20\_\_\_\_

Pursuant to NAC 654.100, Section 2, Subsections (a) and (b), the AIT will complete at least 1000 hours of training in a period of not less than 26 weeks in the Five-Step Program Administrator-in-Training Internship Manual published by NAB.

I fully understand my responsibilities and course content areas for the Administrator-In Training program.

I further agree to inform the Board immediately if there is any change in this arrangement.

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

Date: \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
*Printed Name*

Date: \_\_\_\_\_ 20\_\_\_\_

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

Date: \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
*Printed Name*

Date: \_\_\_\_\_ 20\_\_\_\_

Reviewed by BELTCA \_\_\_\_\_

Date: \_\_\_\_\_ 20\_\_\_\_

Accepted: \_\_\_\_\_

Date: \_\_\_\_\_ 20\_\_\_\_



**PROGRAM CHANGES, cont'd**

submitted to BELTCA. BELTCA must approve Preceptor and/or Facility changes. You must inform BELTCA if you stop your program for 30 days or more, and request approval to restart the program. Please allow up to 30 days processing for all program change requests.

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**EXAMINATION**

Your AIT Program must be completed and your evaluation reports submitted and approved by BELTCA prior to your participating in the examination. Your examination application must be received no later than 30 days prior to the scheduled examination date.

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If you have any questions during your AIT Training Program, please do not hesitate to contact the Board office at (702) 486-5445 or by electronic mail at [belzca@belzca.nv.gov](mailto:belzca@belzca.nv.gov)

# AIT CERTIFICATION OF PROGRAM COMPLETION

Name of AIT: \_\_\_\_\_  
                            First                            Middle                            Last

Place of Training: \_\_\_\_\_

Full mailing name and street address of nursing facility \_\_\_\_\_ zip code \_\_\_\_\_

Telephone \_\_\_\_\_ - \_\_\_\_\_

Date internship began: \_\_\_\_\_ completed: \_\_\_\_\_

Number of weeks/hours spent in:

1. RESIDENT CARE AND QUALITY OF LIFE::

- (1) Nursing \_\_\_\_\_
- (2) Medical/Patient Records \_\_\_\_\_
- (3) Dietary \_\_\_\_\_
- (4) Rehab Services \_\_\_\_\_
- (5) Activity/Social Services \_\_\_\_\_

2. HUMAN RESOURCES:

- (1) Human Resources \_\_\_\_\_
- (2) Payroll/Benefits \_\_\_\_\_
- (3) Staff Development \_\_\_\_\_

3. FINANCE:

- (1) Business Office \_\_\_\_\_
- (2) Central Supply Services \_\_\_\_\_

4. PHYSICAL ENVIRONMENT AND ATMOSPHERE:

- (1) Environment Maintenance \_\_\_\_\_
- (2) Housekeeping \_\_\_\_\_
- (3) Laundry \_\_\_\_\_

5. LEADERSHIP AND MANAGEMENT:

- (1) Administration \_\_\_\_\_
- (2) Additional Clinical Experiences \_\_\_\_\_

**TOTAL NUMBER OF WEEKS/HOURS IN AIT TRAINING PROGRAM** \_\_\_\_\_  
I certify that the AIT whose signature appears below has satisfactorily completed this internship of \_\_\_\_\_ weeks/hours under my personal supervision.

**Narrative evaluation of suitability for licensure as a nursing facility administrator:**  
(use additional pages as necessary)

\_\_\_\_\_  
**PRECEPTOR**

License number: \_\_\_\_\_

\_\_\_\_\_  
ADMINISTRATOR-IN-TRAINING

DATE: \_\_\_\_\_

**ADMINISTRATOR IN TRAINING QUARTERLY REPORTS**

**FIRST QUARTER** – Total AIT training hours for the quarter \_\_\_\_\_ Start Date \_\_\_\_\_ Ending Date \_\_\_\_\_  
Actual hours per week of supervised training \_\_\_\_\_

**PROGRAM CHANGE(S) THIS QUARTER** (briefly explain in detail):

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\_\_\_\_ Supporting documentation attached validating first quarter completion and/or changes.

How would you rate the AIT's Attendance? \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor  
How many hours did you personally train this AIT? \_\_\_\_\_  
Did anyone else assist the AIT with his/her training? If so, please list name and title.

\_\_\_\_\_  
Please list the training topics that were covered during this quarter?

\_\_\_\_\_  
\_\_\_\_\_

Do you as the preceptor recommend the AIT progress to the next quarter of training? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If no, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Preceptor's Signature \_\_\_\_\_ Date \_\_\_\_\_ AIT's Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECOND QUARTER** – Total AIT training hours for the quarter \_\_\_\_\_ Start Date \_\_\_\_\_ Ending Date \_\_\_\_\_  
Actual hours per week of supervised training \_\_\_\_\_

**PROGRAM CHANGE(S) THIS QUARTER** (briefly explain in detail):

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\_\_\_\_ Supporting documentation attached validating first quarter completion and/or changes.

How would you rate the AIT's Attendance? \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor  
How many hours did you personally train this AIT? \_\_\_\_\_  
Did anyone else assist the AIT with his/her training? If so, please list name and title.

\_\_\_\_\_  
Please list the training topics that were covered during this quarter?

\_\_\_\_\_  
\_\_\_\_\_

Do you as the preceptor recommend the AIT progress to the next quarter of training? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If no, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Preceptor's Signature \_\_\_\_\_ Date \_\_\_\_\_ AIT's Signature \_\_\_\_\_ Date \_\_\_\_\_

