State of California – Health and Human Services Agency

California Department of Public Health (CDPH)
Nursing Home Administrator Program (NHAP)
MS 3302, P.O. Box 997416
Sacramento, CA 95899-7416
(916) 552-8780 FAX (916) 552-8777
NHAP@cdph.ca.gov

AIT PROGRAM APPLICATION FOR RE-TRAINING

Return this completed form with a check or money order (made payable to NHAP) with the appropriate fees to the following address:

Nursing Home Administrators Program (NHAP)
MS 3302
P.O. Box 997146
Sacramento, CA 95899-7416

For a current **fee list**, please visit our website at: www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/NHAPFees.aspx

APPLICANT'S NAME (Last)	(First)	(M.I)	SOCIAL SECURITY NUMBER*
MAILING ADDRESS (Number) (Street)			WORK TELEPHONE NUMBER
(City)	(County)	(State) (Zip Code)	HOME TELEPHONE NUMBER
E-MAIL ADDRESS (Optional	FAX NUMBER (Optional)		DATE OF BIRTH

*Social Security Number Disclosure: Pursuant to Section 666(a)(13) of Title 42 of the United States Code and California Family Code Section 17520, subdivision (d), the California Department of Public Health (CDPH) is required to collect social security numbers from all applicants for nursing home administrator licenses. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support orders upon request by the Department of Child Support Services, collection of delinquent State taxes if applicant appears on the Franchise Tax Board's top 500 delinquent taxpayers list pursuant to Business Codes Section 494.5 Subdivision (4), and for reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR, Section 61.1 *et seq.* Failure to provide your social security number will result in the return of your application. Your social security number will be used by CDPH for internal identification, and may be used to verify information on your application, to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.

****CERTIFICATION – IMPORTANT – PLEASE READ BEFORE SIGNING – If not signed this application may be rejected.**

I certify under penalty of the perjury laws of the State of California that the information I have entered on this application (pg. 1-4) is true and correct. I further understand that any false, incomplete, or incorrect statements may result in denial of this AIT application and/or disqualification of the AIT's hours with the Nursing Home Administrator Program (NHAP). I authorize the employers and educational institutions identified on this application to release any information they may have concerning my employment or education to the State of California NHA P.

APPLICANT'S SIGNATURE**	DATE**

PRECEPTOR INFORMATION – TO BE COMPLETED BY PRECEPTOR

PRECEPTOR'S NAME (Last)	(First)		(Middle)
NHA LICENSE NUMBER	NHA LICENSE EXPIRATION DATE	PRECEPTOR NUMBER	PRECEPTOR EXPIRATION DATE

PRECEPTOR'S PRINCIPAL JOB(S)/TITLES

NAME OF FACILITY, OFFICE OR CORPORATION		TELEPHONE NUMBER	
ADDRESS OF FACILITY, OFFICE OR CORPORATION (NUMBER AND STREET)	(City)	(State)	(Zip Code)
NAME OF SNF/ICF TRAINING WILL TAKE PLACE		TELEPHONE NUMBER	
ADDRESS OF SNF/ICF WHERE TRAINING WILLTAKE PLACE (NUMBER AND STREET)	(City)	(State)	(Zip Code)

TRAINING CURRICULUM/AREAS OF FOCUS

NUMBER OF HOURS PER WEEK AIT WILL BE TRAINING	NUMBER OF HOURS PER WEEK YOU, AS THE PRECEPTOR, WILL BE PERSONALLY SUPERVISING THE TRAINIGN OF THE AIT ☐ Minimum 20 ☐ 30 ☐ 40 ☐ 50 ☐ Maximum 60 ☐ Other _____

I declare under penalty of perjury under the laws of the State of California that the information furnished in section 11 is true and correct. I hereby agree to make it my personal responsibility to see that the Administrator-In-Training (AIT) receives the type and amount of training required to make him/her fully qualified to become a licensed Nursing Home Administrator. I will comply with all the requirements of the AIT program, as set forth in the rules and regulation of the State Nursing Home Administrator Program (Health and Safety Code, Chapter 2.35). I understand that failure to supervise the AIT as indiciated above will result in the AIT's training hours being disqualified and may result in suspension of my California Preceptor certificate.

PRECEPTOR'S SIGNATURE	DATE

APPLICANTS – DO NOT USE THE SPACE BELOW – FOR NHAP USE ONLY

FOR NHAP USE ONLY

CASH # _____ NHAP INITIALS _____ AMOUNT _____	STATUS ☐ Approved ☐ Rejected ☐ Denied	
	☐ Unopened Transcripts	☐ Training Outline
	☐ Fingerprints	☐ AIT# ☐ Preceptor Approved
	STAFF	DATE PROCESSED

All information requested by the application is required by the California Department of Public Health, Nursing Home Administrator Program (NHAP). Maintenance of the information requested on this form is authorized by the Health and Safety Code. ***Failure to provide any of the required information will result in the application being rejected as incomplete.*** *For more information or access to records containing your personal information maintained by CDPH, contact the NHAP, MS 3302, P.O. Box 997416, Sacramento, CA 94899-7416, (916) 552-8780.*