



## ADMINISTRATOR-IN-TRAINING MONTHLY REPORT

### INSTRUCTIONS

The Preceptor and Administrator-in-Training (AIT) are to record training **each month and complete the monthly report**. The Preceptor and the AIT may either submit the reports monthly to the Board office, or you may submit all of the monthly reports (1 report per month) with the Documentation of Completion form once the training has been completed. All monthly reports and forms are to be signed by the Preceptor and AIT.

FULL NAME OF AIT

EMAIL ADDRESS OF AIT

NAME OF TRAINING FACILITY

PHONE NUMBER OF TRAINING FACILITY

FULL NAME OF PRECEPTOR

PHONE NUMBER OF PRECEPTOR

EMAIL ADDRESS OF PRECEPTOR

**1. LIST ASSIGNMENTS AND DEPARTMENTS WITH TIME SPENT IN EACH:**

Use additional paper if needed. (Example: laundry service – 8 hours: participated in laundry sanitation and developed a process for clothing identification.)

Click or tap here to enter text.

**2. SUMMARY OF LEARNING EXPERIENCES:**

Click or tap here to enter text.

**3. STATEMENT OF PROBLEM(S) THAT AROSE DURING THE TRAINING, ANALYSIS, AND INSIGHTS GAINED:**

Describe a problem or problems that arose during the training, your role in resolving the problem(s), and what insights you gained during the process. (Examples include problems at the facility; issues with AIT training; difficulties encountered in the performance of AIT duties)

Click or tap here to enter text.

**4. VISITS OUTSIDE THE FACILITY, EDUCATIONAL CONFERENCES, IN-SERVICE EDUCATION ATTENDED, AND TIME:**

Click or tap here to enter text.



Date	Start Time	End Time		Shift Worked	Hours Worked
Date	Time AM/PM	Time AM/PM	Day Type	Shift	
Date	Time AM/PM	Time AM/PM	Day Type	Shift	
Date	Time AM/PM	Time AM/PM	Day Type	Shift	
				TOTAL HOURS	

Did the AIT serve weekday, evening, night, and weekend shifts this month?  Yes  No

Did the AIT complete no more than 40 hours of training per week?  Yes  No

Did the AIT complete training on the care of residents with cognitive or mental impairments, including Alzheimer’s disease and dementia, during this training period?  Yes  No

**AFFIDAVIT OF APPLICANT**

I hereby certify that this report is true and accurate, that I received the training indicated during this reporting period, and that the information is from the records of the above-named training facility, which are available for examination upon request by the Virginia State Board of Long-Term Care Administrators (“Board”) or any of its personnel. Further, I attest that I have complied with all applicable laws and regulations governing the practice of nursing home administrators or assisted living facility administrators. I understand that any false statements or misleading information provided herein shall be sufficient grounds for discipline of my AIT registration or subsequent licensure by the Board, even though it is not discovered until after the completion of my AIT program or issuance of licensure.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**AFFIDAVIT OF PRECEPTOR**

I hereby certify that this report is true and accurate and that the information, as indicated in the departments/areas listed, was under personal supervision in the practice of nursing home administration or assisted living facility administration. I hereby certify that I provided direct instruction, planning, and evaluation and continually evaluated the development and experience of the trainee to determine specific areas needed for concentration. I understand that any false statements or misleading information provided herein shall be sufficient grounds for discipline by the Board of my registration as a preceptor or of my license as an administrator.

I certify that I was routinely present with the trainee for on-site supervision in the training facility as appropriate to the experience and training of the AIT and the needs of the residents in the facility.

If applicable – for preceptors of Acting ALF Administrators-In-Training (AITs): I certify that I was present in the training facility and provided face-to-face instruction and review of the performance of the Acting ALF Administrator-In-Training (AIT) herein for a minimum of four (4) hours per week.

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

\_\_\_\_\_  
Date