PRECEPTOR'S FINAL REPORT

Name of AIT: _____
FIRST MIDDLE LAST

Place of Training: _____

_____
Full mailing name and street address of nursing facility to include zip code

Telephone (_____)-_____

Date Internship began: _____ completed: _____

Number of hours spent in:

1. Administration _____
2. Human Resources _____
3. Nursing Department _____
4. Rehabilitation Department _____
5. Medical/Patient Records _____
6. Activities Department _____
7. Social Services/Admissions _____
8. Business Office _____
9. Dietary Department _____
10. Housekeeping/Laundry _____
11. Environment/Maintenance _____
12. Other _____

TOTAL NUMBER OF HOURS IN AIT TRAINING PROGRAM: _____0_____

Provide narrative evaluation of suitability for licensure as a long term care administrator on separate page.

I certify that the AIT whose signature appears below has satisfactorily completed this Internship of _____0_____ hours under my personal supervision.

_____
PRECEPTOR

_____ DATE: _____
ADMINISTRATOR-IN-TRAINING

(490:10-8-8)

NARRATIVE: