NC STATE BOARD OF EXAMINERS FOR
NURSING HOME ADMINISTRATORS
3733 NATIONAL DRIVE, SUITE 110
RALEIGH, NC 27612

EVALUATION OF TRAINING

NAME OF AIT _____

My Evaluation of the above AIT is: (A=Excellent; B=Good;*C=Fair;*D=Unsatisfactory)

		Circle Appropriate Letter			
1.	**Ability to meet people**	**A**	**B**	**C**	**D**
	Ability to cooperate	**A**	**B**	**C**	**D**
	Ability to work with others	**A**	**B**	**C**	**D**
	Ability to communicate	**A**	**B**	**C**	**D**
2.	**Conduct toward patients**	**A**	**B**	**C**	**D**
	Conduct toward employees	**A**	**B**	**C**	**D**
	Conduct toward preceptor	**A**	**B**	**C**	**D**
	Conduct toward instruction	**A**	**B**	**C**	**D**
3.	**Personal self-confidence**	**A**	**B**	**C**	**D**
	Personal self-discipline	**A**	**B**	**C**	**D**
	Personal hygiene	**A**	**B**	**C**	**D**
4.	**Ability to comprehend**	**A**	**B**	**C**	**D**
	Ability to be instructed	**A**	**B**	**C**	**D**
	Ability to receive criticism	**A**	**B**	**C**	**D**
	Ability to instruct others	**A**	**B**	**C**	**D**
5.	**Interest in profession**	**A**	**B**	**C**	**D**
	Interest in allied professions	**A**	**B**	**C**	**D**
	Interest in patients	**A**	**B**	**C**	**D**
	Interest in employees	**A**	**B**	**C**	**D**

***PLEASE EXPLAIN EACH EVALUATION OF C OR D ON AN ATTACHED SHEET**

The above is my evaluation of, and I have also read the Monthly/Weekly AIT Reports of

_____ whose training I have supervised from _____ to

_____ and consider them to be correct statements of fact.

_____

DATE **LICENSE #** **Signature of Preceptor**

CERTIFICATE OF COMPLETION FOR THE ADMINISTRATOR-IN-TRAINING PROGRAM

Name of AIT _____

Facility _____

Address _____ **City** _____

State _____ **Telephone Number** _____

Date Internship Began: _____ **Completed:** _____

NUMBER OF WEEKS COMPLETED IN EACH OF THE FOLLOWING:

Orientation	_____	**Social Serv./Marketing/Admissions**	_____
Administration	_____	**Housekeeping/Laundry**	_____
Personnel	_____	**Environmental/Maintenance**	_____
Nursing	_____	**Corporate Office**	_____
Rehabilitation	_____	**Out of Facility Visits**	_____
Medical Records	_____	**Nursing Assistant Training**	_____
Activities	_____	**Dietary**	_____
Business Office	_____		

TOTAL NUMBER OF WEEKS IN AIT PROGRAM _____

I, being a duly licensed nursing home administrator in this state, do hereby personally certify that the above individual has served in the capacity of an "Administrator-In-Training" a minimum of forty hours per week for _____weeks as outlined in the curriculum approved by the Board. I further understand that certification of an untruth may result in revocation of my nursing home administrator license and the privileges thereto.

_____
Nursing Home Administrator/Preceptor

_____
License Number

Sworn to and subscribed before me this _____ day of _____, 20 _____.

_____
Notary Public **Seal**

My Commission Expires _____

County of _____
State of _____