

**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 _____