South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of
Long Term Health Care Administrators

110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4544 • Contact.LTHCA@llr.sc.gov • Fax: 803-896-4515
llr.sc.gov/lthc

ADMINISTRATOR-IN-TRAINING PERMIT RENEWAL APPLICATION

Include with your application:

For Board Use Only	
Permit#	
Check #	
Issued	
Amount paid	

- Check or money order (no cash) in the amount of $25 made payable to LL-Board of LTHCA. Application fee is non-refundable. A returned check fee of up to $30, or an amount specified by law, **may** be assessed on all returned funds.

APPLICANT INFORMATION:

NAME:____ Permit#__________
LAST FIRST MIDDLE

ADDRESS: ____

CITY: ____________________________________STATE: _________ ZIP: ___________

HOME PHONE: (______)____________________ BUSINESS PHONE: (______)____________

EMAIL ADDRESS______________________________

WORK HISTORY

List jobs held since your previous AIT Application was submitted

COMPANY NAME:____

ADDRESS:________________________ CITY: _____________ STATE: _____ZIP: _____________

TELEPHONE NUMBER (BUSINESS HOURS): (_______)____

JOB TITLE: _____________________________ DATES WORKED FROM: ______TO: ________

DUTIES and RESPONSIBILITIES: ____

____

SUPERVISOR'S NAME AND TITLE: ____

COMPANY NAME:____

ADDRESS:______________________________ CITY: _____________ STATE: _____ZIP: ________

TELEPHONE NUMBER (BUSINESS HOURS): (_______) ___________________________________

JOB TITLE: _______________________ DATES WORKED FROM: ________TO: _____________

DUTIES and RESPONSIBILITIES: ____

____

SUPERVISOR'S NAME AND TITLE: ____

ADDITIONAL LONG TERM CARE EXPERIENCE: ____

____

____

AFFIDAVIT

I, ____, am the person described and identified, of good moral character, and the person named in all documents presented in this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial of admission to the Administrator-in-Training Program under the Board of Long Term Health Care Administrators.

Applicant's Signature ______________________________________ Date ____________

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

Signature of Notary Public ____

My Commission Expires ____________________________

Seal Required Here