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
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COMMUNITY RESIDENTIAL CARE FACILITY
ADMINISTRATOR-IN-TRAINING MONTHLY REPORT

Reports must be received by the 5th of each month. The AIT Daily Hours Log must be attached to report. Monthly reports submitted without the log will not be processed.

AIT Participant Name:____________________________ AIT Participant No.: _______________________

Preceptor Name: _________________________________ Facility Name:____________________________

Preceptor License Number: _________________ License Type:☐Community Residential ☐Dual License

Dates Covered by this Report: From:_________________ To: ________________

ASSIGNMENTS (*If additional space is needed, attach a separate sheet of paper*)

Assignment Summary: ____________________________ Department: ______________________ Hours: _______
Description: ____
____
____

Assignment Summary: ____________________________ Department: ______________________ Hours: _______
Description: ____
____
____

Assignment Summary: ____________________________ Department: ______________________ Hours: _______
Description: ____
____
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Assignment Summary: ____________________________ Department: ______________________ Hours: _______
Description: ____
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Assignment Summary: ____________________________ Department: ______________________ Hours: _______
Description: ____
____
____

PROBLEMS AND RESOLUTIONS

List any problems that arose and provide description of resolution: ____

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____

OUTSIDE EXPERIENCES

List any outside experiences (visits, meetings, etc.) ____

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ATTESTATIONS

I certify to the best of my knowledge that the information reported above and on the daily hours log is true and accurate and that I have met at least weekly with the listed AIT participant.

____ ____________________

Preceptor Signature Date

Community Residential Facility AIT Daily Hours Log

AIT Participant Name:_____________________________ AIT Participant No.: ________________________

Preceptor Name: __________________________________ Facility Name:_____________________________

Date	**Description**	**Administration**	**Human Resources**	**Medical Records**	**Activities**	**Social Services/Admissions**	**Business Office**	**Dietary**	**Housekeeping/Laundry**	**Maintenance/Environmental**	**Other**	**Daily Total**
												0
												0
												0
												0
												0
												0
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