



Virginia Department of
Health Professions
Board of Long-Term Care Administrators

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NURSING HOME ADMINISTRATOR-IN-TRAINING NOTICE OF CHANGE OF STATUS OR DISCONTINUANCE

(PLEASE PRINT IN BLUE OR BLACK INK)

FIRST NAME	MIDDLE NAME	LAST NAME AND SUFFIX
SOCIAL SECURITY NO. OR VA CONTROL NO.*		
HOME PHONE:	WORK PHONE:	MOBILE PHONE:
E-MAIL ADDRESS		
TRAINING FACILITY NAME	TRAINING FACILITY TELEPHONE NUMBER	
PRECEPTOR NAME	PRECEPTOR'S TELEPHONE NUMBER	

Change Request (Check all that apply)

<input type="checkbox"/> Change of Preceptor Effective Date:	
From:	License No.:
To:	License No.:
New Facility Address:	New Facility Telephone Number:
<input type="checkbox"/> Discontinuance of Administrator-in-Training Program (Board must be notified with 10 business days)	Effective Date:
<input type="checkbox"/> Program Extension	How Many Months?
<input type="checkbox"/> Withdrawal as a Certified Preceptor from AIT Program	Effective Date:
<input type="checkbox"/> Other (specify and document)	Effective Date:
Reasons and Comments:	

Signature of Applicant

Date

Signature of Preceptor

Date