PRELIMINARY DATA FOR AIT PROGRAM

Please fill in the following information:

PERSONAL

Name
Street Address
City/State/Zip

COLLEGE BACKGROUND

Name of College/University
City/State
Major/Area of Concentration
Degree Granted
Date Degree Granted

PROPOSED TRAINING SITE AND PRECEPTOR

Site of Internship: (Nursing Home)
Street Address
Licensed Administrator of Internship:

Return to:

BOARD OF EXECUTIVES OF LONG-TERM SERVICES & SUPPORTS
BELTSS
50 West Broad Street, 9th floor
Columbus, Ohio 43215
Phone No. (614) 466-5114
Fax (614) 466-0271

BELTSS USE ONLY

DATE RECEIVED_____ DATE RESPONDED_____ PROCESSED BY_____