FACILITIES STAFF WORK SCHEDULE

INSTRUCTIONS: This form is to be completed by the licensing evaluator and reviewed by the licensing supervisor.

The purpose of this form is to review staff coverage in large Residential Facilities for 24-hours per day covering a (3) three-week period to ensure sufficient staff coverage. CAREFULLY review split shifts, weekend coverage and irregular days off to ensure sufficient staff coverage.

FACILITY NAME	FACILITY NUMBER	FACILITY TYPE	FACILITY CAPACITY

CLIENT/RESIDENT CENSUS	LICENSING EVALUATOR	DATE

For The Month(s) _____ **20** _____

SERVICE AREA AND WORK TITLE	Enter Dates of Week							Enter Dates of Week							Enter Dates of Week						
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
1. Care and Supervision (e.g., Aides)	Enter Work Hours							Enter Work Hours							Enter Work Hours						
Employee Name(s)																					
2. Food Services (e.g, includes cook, dishwasher)																					
Employee Name(s)																					

FACILITY NAME/NUMBER

FACILITY STAFF WORK SCHEDULE (Continued)

For The Month(s) 20

SERVICE AREA AND WORK TITLE	Enter Dates of Week							Enter Dates of Week							Enter Dates of Week						
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
3. Housekeeping (e.g. Maid)	Enter Work Hours							Enter Work Hours							Enter Work Hours						
Employee Name(s)																					
4. Administrative/Clerical Staff																					
Employee Name(s)																					
5. Transportation/Maintenance																					
Employee Name(s)																					
6. Other (specify other service areas below)																					
Employee Name(s)																					