STAFF REVIEW FOR RESIDENTIAL FACILITIES

FACILITY NAME	VENDOR NUMBER	DATE OF REVIEW
TYPE OF VISIT ❒ ANNUAL ❒ Q.A. EVALUATION ❒ COMPLAINT ❒ OTHER____________	REVIEWER	

RECORD REVIEW

	STAFF NAME	JOB TITLE	DATE EMPLOYED	JOB APPLICATION (18+)	FINGERPRINT		*HEALTH REPORT	*T.B. TEST	*FIRST AID	* *CPR*	DRIVER=S LICENSE *(exp. date)*
					SENT	CLEARED					
1											
2											
3											
4											
5											
6											
7											

TRAINING REVIEW

Level 4 Facilities Only

	STAFF NAME	ON-SITE ORIENTATION *(w/in 40hrs of hire)*	ON THE JOB TRAINING *(as needed for IPPs)*	DSP CERT *(35 hrs)*		CONTINUING EDUCATION	DD exp. *(# of mos)*	if less than 6 mo. exp. / 12hrs w/n 6 mo. of hire	PART/ CPI w/in 60 days	COMMENTS
				1ST	2ND					
1										
2										
3										
4										
5										
6										
7										

= list applicable dates