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)																					
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