

STAFF REVIEW FOR RESIDENTIAL FACILITIES

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FACILITY NAME									DATE OF REVIEW			
TYPE	OF VISIT	ITION COMPLAINT COTHER					REVIEWER					
RECC	ORD REVIEW											
	STAFF NAME	JOB TITLE	DATE EMPLOYEI		JOB APPLICATION (18+)	FIN	GERPRINT	*HEALTH REPORT	*T.B. TEST	*FIRST AID	* CPR	DRIVER=S LICENSE (exp. date)
	STAFF NAME	IIILE	EMPLOYEL	, ,		SENT	CLEARED					
1												
2												
3												
4												
5												
6												
7												
TRAINING REVIEW Level 4 Facilities Only												
STAFF NAME		ON-SITE ORIENTATION	ON THE JOB TRAINING	DSP CERT	C	ONTINUING DUCATION	DD exp. (# of mos)	if less than 6 mo. exp. / 12hrs w/n		PART/ CPI w/in COMMENTS		

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

^{*=} list applicable dates

ELARC 527 (6/233)