Print Form

Save Copy

THREE-WEEK NURSING SCHEDULE

			PLEASE RETURN COMPLETED FORM BY:	
Facility:			Date of Survey:	

Please list the number of hours worked by R.N.s and L.P.N.s aides and/or orderlies assigned to nursing duty for the last three complete weeks available. (DO NOT include the first 16 hours of new employee orientation)

Director of Nursing counted in:	YES:		NO:	
Restorative Aides counted in:	YES:		NO:	

WEEK OF:

SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DAY																					
EVENING																					
NIGHT																					
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CENSUS																					

WEEK OF:

SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DAY										0.00											
EVENING																					
NIGHT																					
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CENSUS																					

WEEK OF:

SHIFT	SUNDAY			MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY		
	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A	RN	PN	A
DAY																					
EVENING																					
NIGHT																					
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
CENSUS																					