

OUT PATIENT FACILITY PROFILE

- 1. Name of the parent organization: _____
Name/title of CEO: _____
- 2. Survey report should be mailed to: _____
Mailing address: _____
E-mail &/or Fax: _____

INFORMATION SPECIFIC TO THIS SURVEY:

DATE/s _____

- 3. Name of facility: _____
Name/title of person in charge _____
Physical address: _____

Phone number/s: _____
- 4. Name/title of medical director: _____
Total number of physicians: _____ PAs: _____ APRN: _____
- 5. Name/title of nursing supervisor _____
Total number of RNs: _____ LPNs: _____
Number/titles of other direct care staff _____
- 6. Staffing patterns: Mon-Fri: Day _____ Eve: _____ Night: _____
Sat-Sun _____

Notes: _____

7. Other professionals: _____

Identify the person/s responsible for the following:

Note if by contract or arrangement with another agency:

Building Maintenance: _____

Housekeeping: _____

Medical Records: _____