付表３

（表）

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 訪問看護・介護予防訪問看護事業者の指定に係る記載事項 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 事業所 | | フリガナ | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 名称 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 所在地 | | (郵便番号　　―　　　) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 連絡先 | | 電話番号 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | FAX番号 | | | | | |  | | | | | | | | | |
| 実施主体が地方公共団体である場合は、当該事業の実施について定めてある条例等の条文 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 第　　　条第　　　項第　　　号 | | | | | | | | | | | | | | | |
| 病院・診療所・その他の訪問看護事業所(訪問看護ステーション)の別（該当に○） | | | | | | | | | | | | | | | | | | | | | 病院 | | | | |  | | | | | | | 診療所 | | | |  | | | | その他の訪問看護事業所(訪問看護ステーション) | | | | | | | |  |
| 管理者 | フリガナ | | | |  | | | | | | | | | | | | | | | | 住所・連絡先 | | | | | | | | (郵便番号　　―　　　) | | | | | | | | | | | | | | | | | | | | |
| 氏名 | | | |  | | | | | | | | | | | | | | | |
| 生年月日 | | | |  | | | | | | | | | | | | | | | | 電話番号 | | | | | | |  | | | | | | | FAX番号 | | | |  | | |
| ※職種 | | | |  | | | | | | | | | | | | | | | | ※登録番号 | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| ※他の職務との兼務の状況(兼務がある場合のみ記入) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 当該訪問看護・介護予防訪問看護事業所内での他の職務との兼務 | | | | | | | | | | | | | | | | 職種 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 同一敷地内の他の事業所の職務との兼務 | | | | | 事業所又は施設の名称及び事業又は施設の種類 | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 兼務する職種及び勤務時間 | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 利用者の推定数 | | | | | | | | 人 | | | | | | | | | | | | | | （前年度の平均値、新規の場合は予測される数を記入） | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 従業者 |  | | | | | | | | | | | 看護師 | | | | | | | | | | 保健師 | | | | | | | | | | | | | 准看護師 | | | | | | | | | 理学療法士・作業療法士・言語聴覚士 | | | | | |
| 専従 | | | | 兼務 | | | | | | 専従 | | | | | | | | | 兼務 | | | | 専従 | | | 兼務 | | | | | | 専従 | | | | 兼務 | |
| 常勤(人) | | | | | | | | | | |  | | | |  | | | | | |  | | | | | | | | |  | | | |  | | |  | | | | | |  | | | |  | |
| 非常勤(人) | | | | | | | | | | |  | | | |  | | | | | |  | | | | | | | | |  | | | |  | | |  | | | | | |  | | | |  | |
| 常勤換算後の人数(人) | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
| ※事業所を兼用する場合のその事業の種類(兼用の場合に記入) | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 主な掲示事項 | 営業日 | | | | | 日 | 月 | | | | | | 火 | 水 | | | 木 | | | 金 | | | | 土 | | | 祝 | | | | | その他  年間の休日 | | | | | | | | |  | | | | | | | | |
|  |  | | | | | |  |  | | |  | | |  | | | |  | | |  | | | | |
| 営業時間 | | | | | 平日 | | | | ～ | | | | | | | | | | | | | 土曜 | | | | | | | ～ | | | | | | | | | | | | 日・祝 | | | ～ | | | | |
| 備考 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 利用料 | | | | | 法定代理受領分　　　　介護報酬告示上の額 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 法定代理受領分以外　　介護報酬告示上の額 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| その他の費用 | | | | | 運営規程に定めるとおり | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 通常の事業実施地域 | | | | | ① | | | | | | | | | ② | | | | | | | | | | | | | | | | ③ | | | | | | | | ④ | | | | | | | ⑤ | | | |
| 備考 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 備考　１　※印の欄には、病院及び診療所以外の訪問看護事業所(訪問看護ステーション)の場合のみ記入すること。  　　　　２　記入欄が不足する場合は、別に記入した書類を添付すること。（裏面に続く。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |