付表７

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 通所リハビリテーション・介護予防通所リハビリテーション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 | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | |  | | | |
| 管理者代行者が選任されている場合 | | | | | | | | | 医師 | | | | | | | | | | |  | | | 作業療法士 | | | | | | | | |  | | | 専従の  看護師 | | | | | | | |  | | | | | 代行  者名 | | | | | フリガナ | | | | | | |  | | |
| 理学療法士 | | | | | | | | | | |  | | | 言語聴覚士 | | | | | | | | |  | | | 氏名 | | | | | | |  | | |
| 事業所の種別(該当に○) | | | | | | 病院 | | | | | | |  | | | | | | | | | | 診療所(利用者の数が10人を超える場合) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 診療所(利用者の数が10人以下の場合) | | | | | | | | | | | | | |  | | | | | | | | 介護老人保健施設 | | | | | | | | | | | | |  | | | | | | | | | | | | 介護医療院 | | | | | | | | | | |  |
| 上記事業所の種別が介護老人保健施設又は介護医療院の場合 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 入所者数(定員) | | | | | | | 人 | | | | | | | | | | | | | | | | | | 施設開設年月日 | | | | | | 年　　月　　日 | | | | | |
| 実施単位数 | | | | | | | 単位 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医師数 | | | | 常勤 | | | 人 | | | | | | | | | | 一日当たりの総利用者数(定員合計) | | | | | | | | | | | | | | | | | | | | | 人 | | | | | | | | 専用の部屋等の面積(合計) | | | | | | | | | | | | | | | | | m2 | |
| 非常勤 | | | 人 | | | | | | | | | |
| 単位別情報(１単位目) | ※２単位目以降は、別紙に記載し、添付すること。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 従業者 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 常勤(人) | | | | | | | | | | 非常勤(人) | | | | | | | | | 常勤換算後の人数(人) | | | | | | |
| 理学療法士  作業療法士  言語聴覚士 | | | | | | ①当該単位につき毎日従事する者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | |
| ②①以外の者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | |
| 看護師  准看護師 | | | | | | ③経験を有する看護師 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | |
| ④③以外の看護師又は准看護師 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | |
| 介護職員 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | |
| 栄養職員 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | |
| 歯科職員 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | |
| 利用定員 | | | | | | | 人 | | | | | | | | | | | | | | | | 専用の部屋等の面積 | | | | | | | | | | | | | | | | m2 | | | | | | | | | | | | | | | |  | | | | | | | | |
| 営業日 | | | | | | | 日 | | | | 月 | | | | | | 火 | 水 | | | | | 木 | | 金 | | | 土 | | | 祝 | | | | その他年間の休日 | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | |  |  | | | | |  | |  | | |  | | |  | | | |
| 送迎を除くサービス提供時間 | | | | | | | 平日 | | | | | | | ～ | | | | | | | | | | | 土曜 | | | | ～ | | | | | | | | | | | | | | | | | | | | | | 日・祝 | | | | | ～ | | | | | | | |
| 備考 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 主な掲示事項 | 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　２単位以上実施する場合は、別紙に記載し、添付すること。  　　　　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。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |