<Name of Tribe> - <Name of Program>
Long Term Care Ombudsman Program
Staff and Volunteer Time Sheet

NAME (Print): _____ MONTH: _____ YEAR: _____ REGION 8

DATE	SKILLED NURSING FACILITY	# Residents Seen	ASSISTED LIVING FACILITY	# Residents Seen	OTHER BUSINESS	TIME SPENT (In Hours)
	TOTAL RESIDENTS SEEN	0	TOTAL RESIDENTS SEEN	0	TOTAL TIME SPENT	0

OMBUDSMAN'S SIGNATURE: _____ **DATE:** _____

SUPERVISOR'S SIGNATURE: _____ **DATE:** _____