



Staffing Intake Sheet - Staff MUST be a CNA / HHA or LPN / RN

Facility Information

- 1. Facility's Name: _____
Facility Type (ex:ALF): _____
- 2. Owner: _____
- 3. Administrator: _____
- 4. Telephone: _____ Fax: _____
- 5. Contact Email: _____
- 6. Full Address: _____
- 7. License No.: _____ *Must be in compliance with AHCA or governing Agency for operation.*
- 8. Resident Capacity: _____, if applicable
- 9. Total number of **CNA / HHA / LPN or RN** Staff needed.
CNA: _____ HHA: _____ LPN: _____ RN: _____ Upon Request: _____

SERVICE

Days needed: Sun Mon Tues Wed Thur Fri Sat Sun

Or As needed: Yes No

Hours: _____ or upon request: Yes No

Print Name

Signature of Authorized Personnel Only

Date: _____

RETURN TO: FAX: 305-956-5150 OR EMAIL: healthunited@yahoo.com