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<table>
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<tbody>
<tr>
<td><strong>NAME OF FACILITY</strong></td>
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<tr>
<td><strong>ADDRESS</strong></td>
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<tr>
<td><strong>1. Type of Facility</strong></td>
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<tr>
<td>1.1 General</td>
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<tr>
<td>1.2 Psychiatric</td>
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<tr>
<td>1.3 Other (explain)</td>
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<tr>
<td>1.4 Name of the chief administrative officer and title</td>
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<tr>
<td>1.5 What is the purpose of this facility?</td>
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<td>1.6 Facility approved and / or accredited by</td>
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<td>1.7 Licensed by</td>
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<tr>
<td>1.8 List all educational programs having clinical practice experience within the facility and number of students in each program.</td>
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2. Control of Facility

2.1 State ____________________________

2.2 County ____________________________

2.3 City ______________________________

2.4 Private ownership __________________

2.5 Church or Church Organization __________

2.6 Non-Profit Corporation __________________

2.7 Other (explain) _________________________

3. Statistics for year just past:

3.1 Total bed capacity (exclusive of newborn): ______________________

3.2 Daily patient average: ________________________________

3.3 Average hospital days per patient: ____________________________

3.4 Medical patients: Daily average: ____________________________

3.5 Surgical patients: Daily average: ____________________________

3.6 Obstetric patients: Daily average: ____________________________

3.7 Newborn: Daily average: _________________________________

3.8 Pediatric patients: Daily average: __________________________

3.9 Psychiatric patients: Daily average: ________________________

3.10 All others: Daily average: _______________________________

3.11 Total number of out-patients. (Describe the nature of clinics held and extent of your out-patient department services.)

_____________________________________________________________________

_____________________________________________________________________
4. Number of registered professional nurses on payroll:
   4.1 Full-time: ____________________________________________
   4.2 Part-time: ____________________________________________
   4.3 Name of Director / Vice-President of Nursing Service
      _______________________________________________________
   Qualifications and major responsibilities ______________________
   _______________________________________________________

4.4 Name of Director of Education ______________________________
   _______________________________________________________
   Qualifications and major responsibilities ______________________
   _______________________________________________________

5. Number of licensed practical nurses on payroll:
   5.1 Full-time: ____________________________________________
   5.2 Part-time: ____________________________________________

6. Number of certified nurse aides on payroll:
   6.1 Full-time: ____________________________________________
   6.2 Part-time: ____________________________________________

7. Number of other workers employed:
   7.1 Full-time: ____________________________________________
   7.2 Part-time: ____________________________________________

8. Number of nursing service positions budgeted but not filled:
   8.1 Number: ____________________________________________
   8.2 List: ________________________________________________

________________________________________________________________________
Nurse Education Program Administrator Signature __________________________ Date __________