付表7-1

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所の登録に係る記載事項

（病院・診療所）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 事　業　所 | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 名　称 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 所在地 | | | | | （郵便番号　　　－　　　　） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| （ビルの名称等） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 連絡先 | | | | | 電話番号 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | FAX番号 | | | | | | |  | | | | | | | | | | | | | | |
| ﾒｰﾙｱﾄﾞﾚｽ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 当該事業の実施について定めてある定款・寄附行為等の条文 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 第　　　条第　　　項第　　　号 | | | | | | | | | | | | | | | | | | | | | |
| 管　理　者 | フリガナ | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | 住所 | | | | | （郵便番号　　　－　　　　） | | | | | | | | | | | | | | | | | | | | | |
| 氏　名 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 生年月日 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 管理者代行者が選任されている場合 | | | | | | | 医師 | | | | | | | | | | | | | | |  | | | 作業療法士 | | | | | | | | | | | |  | | | 代行  者名 | | | | フリガナ | | | | | |  | | | | | | |
| 理学療法士 | | | | | | | | | | | | | | |  | | | 専従の看護師 | | | | | | | | | | | |  | | | 氏　名 | | | | | |  | | | | | | |
| 事業所の種別（1つに○） | | | | | | | | | 病　院 | | | | | | | | | |  | | | | | | | | 診療所(1) | | | | | | | |  | | | | | 診療所(2) | | | | | | | |  | | | |  | | | | | |
| 実施単位数 | | | |  | | | | 単位 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 専用の部屋等の面積 | | | | | | | |  | | | | | | | | | | | | ㎡ | | | | 基準上の必要数値 | | | | | | | | | | | | | | | | | | | | | | 適合の可否 | | | | | | | | | | | |
| ㎡以上 | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| 医師数 | | | 専従 | | | | |  | | | | | | | | | 人 | | | | | | | 一日当たりの総利用者推定数 | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | 人 | |
| 兼務 | | | | |  | | | | | | | | | 人 | | | | | | |
| （単位別）従業者の職種・員数 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 員数 | | | | | | | | | | 基準上  必要人数(人) | | | | | | 適合の  可否 | | |
| 常勤 | | | | | 非常勤 | | | | |
|  | | 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | |  | | | | |  | | | |
| ②週１日以上従事する上記以外の者 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | |  | | | | |  | | | |
| 看護職員 | | | | | | ③経験看護師等 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | |  | | | | |  | | | |
| ④上記③以外の看護職員 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | |  | | | | |  | | | |
| 介護職員 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | |  | | | | |  | | | |
| 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 | | | |  | | | | ～ | |  | | | 日曜・祝日 | | | | | | | |  | | | ～ | | | |  |
| 備考（ｻｰﾋﾞｽ提供時間等） | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 利用定員 | | | | | | 人 | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 利用料 | | | 法定代理受領分 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 法定代理受領分以外 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| その他の費用 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 通常の事業実施地域 | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 添付書類 | | | | | | | | | | | | | | | | | | 別添のとおり | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

備考　　1　色塗りされている欄には、記入しないでください。

2　記入欄が不足する場合は、適宜欄を設けて記載する又は別紙に記載して添付してください。

3　「主な掲示事項」については、本欄の記載を省略し、別添資料として添付して差し支えありません。

4　本事業所内で複数の単位を実施する場合にあっては、２単位目以降に係る利用定員及び単位別従業者の職種・員数については、「付表7-1別紙」に記載し添付してください。

5　「事業所の種別」の診療所(1)と診療所(2)の違いは以下のとおりです。該当するものを選択してください。

　　診療所(1)　サービスの提供が同時に10人を超える利用者に対して一体的に行われるもの

　　診療所(2)　サービスの提供が同時に10人以下の利用者に対して一体的に行われるもの

付表7-1　（別紙）

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所の登録に係る記載事項

（病院・診療所：2単位目以降）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 事業所 | フリガナ | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 名　　称 | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| ２単位目 | （単位別）従業者の職種・員数 | | | | | | | | | | | | | | | | | | 員数 | | | | 基準上  必要人数（人） | | | | 適合の  可否 | |
| 常勤 | | 非常勤 | |
|  | 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 | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| ②週１日以上従事する上記以外の者 | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| 看護職員 | | ③経験看護師等 | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| ④上記③以外の看護職員 | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| 介護職員 | | | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| 主な提示事項 | 利用定員 | |  | | | | | | 人 | |  | | | | | | | | | | | | | | | | |
| 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 | |  | | ～ | |  | 日曜・祝日 | | |  | ～ | | |  |
| 備考（サービス提供時間等） | | | | | | | | | | | |  | | | | | | | | | | | | |
| ３単位目 | （単位別）従業者の職種・員数 | | | | | | | | | | | | | | | | | | 員数 | | | | 基準上  必要人数(人) | | | | 適合の  可否 | |
| 常勤 | | 非常勤 | |
|  | 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 | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| ②週１日以上従事する上記以外の者 | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| 看護職員 | | ③経験看護師等 | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| ④上記③以外の看護職員 | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| 介護職員 | | | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| 主な掲示事項 | 利用定員 | |  | | | | | | 人 | |  | | | | | | | | | | | | | | | | |
| 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 | |  | | ～ | |  | 日曜・祝日 | | |  | ～ | | |  |
| 備考（サービス提供時間等） | | | | | | | | | | | |  | | | | | | | | | | | | |
| ４単位目 | （単位別）従業者の職種・員数 | | | | | | | | | | | | | | | | | | 員数 | | | | 基準上  必要人数(人) | | | | 適合の  可否 | |
| 常勤 | | 非常勤 | |
|  | 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 | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| ②週１日以上従事する上記以外の者 | | | | | | | | | | | | | | |  | |  | |  | | | |  | |
| 看護職員 | | ③経験看護師等 | | | | | | | | | | | | | | |  | |  | |  | | |  | | |
| ④上記③以外の看護職員 | | | | | | | | | | | | | | |  | |  | |  | | |  | | |
| 介護職員 | | | | | | | | | | | | | | | | |  | |  | |  | | |  | | |
| 主な掲示事項 | 利用定員 | |  | | | | | | 人 | |  | | | | | | | | | | | | | | | | |
| 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 | |  | | ～ | |  | 日曜・祝日 | | |  | ～ | | |  |
| 備考（サービス提供時間等） | | | | | | | | | | | |  | | | | | | | | | | | | |