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| 通所介護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 | | | | | | |  | | | |
| 他の職務との兼務の状況(兼務がある場合のみ記入) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | 当該通所介護事業所内での他の職務との兼務 | | | | | | | | | | | | | | | | | | | | | | | 職種 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 同一敷地内の他の事業所又は施設の職務との兼務 | | | | | | | | | | | 事業所又は施設の名称及び事業又は施設の種類 | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 兼務する職種及び勤務時間 | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 実施単位数 | | | | | | | 単位 | | | | | | | | | 同時に通所介護の提供を受けることができる利用者の数の上限 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人 | | | | |
| 単位ごとの状況 | | | | | | | | | | | | | | | | | | | | | | | | １単位目 | | | | | | | | | | | | | | | | | ２単位目 | | | | | | | | | | | |  | | | | | |  | | | | | 合計 | |
|  | 定員 | | | | | | | | | | | | | | | | | | | | | | | 人 | | | | | | | | | | | | | | | | | 人 | | | | | | | | | | | |  | | | | | |  | | | | | 人 | |
| 食堂及び機能訓練室の合計面積 | | | | | | | | | | | | | | | | | | | | | | | m2 | | | | | | | | | | | | | | | | | m2 | | | | | | | | | | | |  | | | | | |  | | | | | m2 | |
| 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 | |  | | | | | | 生活相談員 | | | | | | | | | 看護師・准看護師 | | | | | | | | | | | | | 介護職員 | | | | | | | | | | 機能訓練指導員 | | | | | | | | | | 栄養職員 | | | | | | | | | 歯科職員 | | |
| 専従 | | | | | | | 兼務 | | 専従 | | | | | | | | 兼務 | | | | | 専従 | | | | | | | | 兼務 | | 専従 | | | | 兼務 | | | | | | 専従 | | | 兼務 | | | | | | 専従 | | 兼務 |
| 常勤(人) | | | | | |  | | | | | | |  | |  | | | | | | | |  | | | | |  | | | | | | | |  | |  | | | |  | | | | | |  | | |  | | | | | |  | |  |
| 非常勤(人) | | | | | |  | | | | | | |  | |  | | | | | | | |  | | | | |  | | | | | | | |  | |  | | | |  | | | | | |  | | |  | | | | | |  | |  |
| 定員 | | | | | | 人 | | | | | | | | | | | | | | | 食堂及び機能訓練室の合計面積 | | | | | | | | | | | | | | | | | | | | | | | | | | | m2 | | | | | |  | | | | | | | |
| 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・祝 | | | | | ～ | | | | | | | | | |
| 送迎を除くサービス提供時間 | | | | | | | | | | | | | | | | | | ：　　～　　：　　(　　　時間　　分) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |