**付表４**

**認知症対応型共同生活介護事業所・介護予防認知症対応型共同生活介護事業所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　　　－　　　　）**  **都道　　　　　市区**  **府県　　　　　町村** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **連絡先** | | **電話番号** | | | | | | | **（内線）** | | | | | | | | | **ＦＡＸ番号** | | | | |  | | | | |
| **Ｅ－ｍａｉｌ** | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **管　理　者** | | **フリガナ** | | |  | | | | | | | | | **住所** | | **（郵便番号　　　－　　　　）** | | | | | | | | | | | | | |
| **氏名** | | |  | | | | | | | | |
| **生年月日** | | | **年 月 日** | | | | | | | | |
| **当該事業所で兼務する他の職種（兼務の場合のみ記入）** | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| **同一敷地内の他の事業所又は施設の従業者との兼務（兼務の場合のみ記入）** | | | | | | | | | | **名称** | |  | | | | | | | | **事業所番号** | | | |  | | | |
| **兼務する職種及び勤務時間等** | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **本体施設の有無** | | | | | **□有　□無** | | | | | | | **本体施設名称** | | | | |  | | | | | | **事業所番号** | | | | |  | |
| **協力医療機関** | | | | | **名称** | | |  | | | | | | | | | | **主な診療科名** | | | | |  | | | | | | |
| **名称** | | |  | | | | | | | | | | **主な診療科名** | | | | |  | | | | | | |
| **○人員に関する基準の確認に必要な事項** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **共同生活住居数** | | | | | **戸** | | | | **①** | | | | | **②** | | | | | | **③** | | | | | |  | | |
| **従業者の職種・員数** | | | | | | | | | **介護従業者** | | | | | **介護従業者** | | | | | | **介護従業者** | | | | | | **計画作成担当者** | | |
| **専従** | | | **兼務** | | **専従** | | | | **兼務** | | **専従** | | | **兼務** | | | **専従** | | **兼務** |
|  | | **常　勤（人）** | | | | | | |  | | |  | |  | | | |  | |  | | |  | | |  | |  |
|  | | **非常勤（人）** | | | | | | |  | | |  | |  | | | |  | |  | | |  | | |  | |  |
| **常勤換算後の人数（人）** | | | | | | |  | | |  | |  | | | |  | |  | | |  | | |  | | |
| **利用者数**  **(推定数を記入)** | | | | | **人** | | | | **人** | | | | | **人** | | | | | | **人** | | | | | |
| **利用定員** | | | | | | | | | **人** | | | | | **人** | | | | | | **人** | | | | | |
| **○設備に関する基準の確認に必要な事項** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **建物の構造** | | | | | | | | **□耐火建築物　　　□準耐火建築物　　　□その他** | | | | | | | | | | | | | | | | | | | | |
| **添付書類** | | | | | | | **別添のとおり** | | | | | | | | | | | | | | | | | | | | | | |

**備考**

**１　記入欄が不足する場合は、適宜欄を設けて記載するか、又は別葉に記載した書類を添付してください。**

**２　管理者の兼務については、添付資料にて確認可能な場合は記載を省略することが可能です。**

**３　協力歯科医療機関がある場合は、「協力医療機関」欄に併せて記載してください。**