

**SAN GABRIEL/POMONA REGIONAL CENTER
STAFF REVIEW FOR RESIDENTIAL FACILITIES**

FACILITY NAME				VENDOR NUMBER		DATE OF REVIEW	
TYPE OF VISIT <input type="checkbox"/> ANNUAL <input type="checkbox"/> Q.A. EVALUATION <input type="checkbox"/> COMPLAINT <input type="checkbox"/> OTHER _____				REVIEWER			

RECORD REVIEW

	STAFF NAME	JOB TITLE	DATE EMPLOYED	JOB APPLICATION (18+)	FINGERPRINT		*HEALTH REPORT	*T.B. TEST	*FIRST AID	* CPR	DRIVER-S LICENSE (exp. date)
					SENT	CLEARED					
1											
2											
3											
4											
5											
6											
7											

TRAINING REVIEW

Level 4 Facilities Only

	STAFF NAME	ON-SITE ORIENTATION (w/in 40hrs of hire)	ON THE JOB TRAINING (as needed for IPPs)	DSP CERT (35 hrs)		CONTINUING EDUCATION	DD exp. (# of mos)	if less than 6 mo. exp. / 12hrs w/n 6 mo. of hire	PART/ CPI w/in 60 days	COMMENTS
				1 ST	2 ND					
1										
2										
3										
4										
5										
6										
7										

* = list applicable dates