

Montana Mental Health Nursing Care Center
Resident Work Program
Resident Assessment for Determination for Rate of Pay

Date of Assessment: _____

Name of Resident: _____

Time: _____

Staff Names: _____

Time: _____

Time: _____

Time: _____

Name	Time (Seconds)	Average (Seconds)	Quantity 90%	Quality 10%

Description of timed assessments:

Remarks on resident's performance:

