

Total Number of Residents \_\_\_\_\_ Please check all that apply: Male Residents [ ] Female Residents [ ]

**PLEASE PRINT ANOTHER COPY OF THIS FORM, IF NEEDED FOR ADDITIONAL SPACE**

**Please complete the following for each full time, part time and relief group home staff member**

Name	Job Position	Date of Hire	D.O.B.	Soc Sec No.	Days/Hours on Duty	Med. Cert. Date	Orientation Hours	Annual Training Hours

To the best of my knowledge and belief, all information I have given to the Department of Public Health and Human Services on this application is true and correct.

\_\_\_\_\_  
**Executive Director or other Official Authorized to Sign**

\_\_\_\_\_  
**Date**

**\*\*Note: Pursuant to 2-5-115, MCA, the QAD Licensure Bureau estimates that your application for license or license renewal will be processed within 60 days of the Division's receipt of ALL application materials/supplements.**