§ 488.105 Long term care survey forms, Part B.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0400

PART B

MEDICARE / MEDICAID SKILLED NURSING FACILITY AND INTERMEDIATE CARE FACILITY SURVEY REPORT

LONG TERM CARE SURVEY

PROVIDER NUMBER	FACILITY NAME AND ADDRESS (*City, State, Zip*)
VENDOR NUMBER	
SURVEY DATE	

SURVEYORS' NAMES	TITLES

SURVEY TEAM COMPOSITION

F1 Indicate the Number of Surveyors According to Discipline:

A.	☐ Administrator		H.	☐ Life Safety Code Specialist	
B.	☐ Nurse		I.	☐ Laboratorian	
C.	☐ Dietitian		J.	☐ Sanitarian	
D.	☐ Pharmacist		K.	☐ Therapist	
E.	☐ Records Administrator		L.	☐ Physician	
F.	☐ Social Worker		M.	☐ National Institute of Mental Health	
G.	☐ Qualified Mental Retardation Professional		N.	☐ Other	

Note: More than one discipline may be marked for surveyors qualified in multiple disciplines.

F2 Indicate the Total Number of Surveyors Onsite: ____________

(CONTINUED ON REVERSE)