(Attachment #8a)

Program Name: _____ Phone #: (____) _____

Location Address: _____Town: _____ License #_____

Mailing Address: _____Town: _____ State: _____ Zip Code_____

Prepared By: (please print) _____ Date: _____

Days & Hours of Operation: Days: _____ Hours: _____ AM to _____ PM

STAFF WORK SCHEDULE FORM

STAFF NAME * ♥	DATE OF BIRTH	POSITION	WORK SCHEDULE DAYS AND HOURS	DATE HIRED

*** Place * (an asterisk) by each person's name who has been First Aid Trained within the last 3 years**

♥ Place ♥ (a heart) by each person's name who has valid CPR Training

RETURN TO: _____