

COVER PAGE

The following is the comprehensive hospital staffing plan for _____ submitted to the Washington State Department of Health in accordance with [Revised Code of Washington 70.41.420](#) for the year _____ .

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Hospital Staffing Form

Attestation

Date:

I, the undersigned with responsibility for attest that the attached hospital staffing plan and matrix are in accordance with RCW 70.41.420 for _____, and includes all units covered under our hospital license under RCW 70.41.

As approved by:

Hospital Information

Name of Hospital:		
Hospital License #:		
Hospital Street Address:		
City/Town:	State:	Zip code:
Is this hospital license affiliated with more than one location?		Yes No
If "Yes" was selected, please provide the location name and address		
Review Type:	Annual	Review Date:
	Update	Next Review Date:
Effective Date:		
Date Approved:		

Hospital Information Continued (Optional)

Factors Considered in the Development of the Hospital Staffing Plan (check all that apply):

Staffing guidelines adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations

Description:

Terms of applicable collective bargaining agreement

Description:

Relevant state and federal laws and rules including those regarding meal and rest breaks and use of overtime and on-call shifts

Description:

Hospital finances and resources

Description:

Other

Description:

Signature

CEO & Co-chairs Name:	Signature:	Date:

Total Votes	
# of Approvals	# of Denials

Click [HERE](#) to access unit staffing matrices

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