DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-62158 (Rev. 07/08)

STATE OF WISCONSIN

LIVING UNIT DIRECT CARE STAFFING REPORT

NIGHT SHIFT

Name – Facility	**NIGHT** Shift Usual Hours	
Name – Living Unit	Review Dates	
	From	To

INSTRUCTIONS

List the name of direct care staff (do not include nurses or other professionals) who worked on the living unit during the time period specified above. Indicate the number of hours worked for each day, i.e., 8, 7.5, 6. Total the columns at the completion of each page and if more than one page is required for a shift, carry the subtotal forward, and provide a total on completion. Express fractions as decimals rounded to the each quarter, i.e., .25, .5 or .75. Refer to DQA form F-62155I for more information.

Name – Direct Care Staff	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Subtotal / Total														