

**OHIO DEPARTMENT OF HEALTH
MATERNITY LICENSURE
MATERNITY HOME REPORT FORM**

Please complete and return to surveyors at the beginning of your maternity licensure inspection

Home: _____ Telephone No: (____) _____

Home Address: _____

Mailing Address (if different than above): _____

County: _____ Antepartum/Nursery Beds: _____/_____

1. ADMINISTRATOR

1. Name: _____

Signature: _____ Title: _____

2. Tenure in Position: _____

3. Experience, Formal Education and Training: _____

2. NURSING STAFF

1. Supervisor:

Name: _____

Ohio License Number: _____

Title: _____

2. Tenure in Position: _____

3. Experience, Formal Education and Training: _____

3. MEDICAL SERVICES

1. Director of Obstetrics:

1. Name: _____

Ohio License Number: _____

2. Qualifications:

1. OB/GYN: _____ Board Certified _____ Eligible

3. Hospital Affiliation: _____

3. Director of Nursery (if applicable):

1. Name: _____

Ohio License Number: _____

2. Qualifications:

1. Pediatrics: _____ Board Certified _____ Eligible

4. OTHER

1. Prenatal Care: _____ On Premises _____ Hospital/Clinic _____ Private Physician

2. Prenatal Education: _____ On Premises _____ Hospital/Clinic

3. Renovation/Construction/Relocation

1. Date of last construction, renovation, or relocation of the maternity home:

2. Is new construction, renovation, or relocation being planned within the current year?

3. If so, give a brief description: _____

LIST OF PERSONNEL (including all volunteers)

[illegible]

Revised 01/01/2012

MATERNITY HOMES AND BIRTHING CENTERS

LIST OF PERSONNEL (including all volunteers)

Name	Ohio License Number	CPR/ NRP	Date of Physical Exam	Date of TB Screening- Skin	Date of TB Screening- Chest

Revised 01/01/2012