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| 様式１  ブロック専任理事印  ブロック専任理事印  **正会員入会申込書（１）**  一般社団法人東京都老人保健施設協会会長 殿  一般社団法人東京都老人保健施設協会に入会を申し込みます｡  平成　　 年 月 日  （ふりがな）  介護老人保健施設名称  （ふりがな）  印   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | 会員役職 | |  | 会員職種  (医師の場合は専門科目) | | （　　　　　　　　） | | | 上記の者を当施設の入会希望者（正会員）として指定します。 | | | | | | | |  | 施設開設者　役職・氏名　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　印 | | | | | | |  | 【理由】 | | | | | | | （開設者及び管理者以外の方を正会員とする場合のみ記名・捺印、理由をご記入下さい） | | | | | | | | （ふりがな）  施設所在地 | | 〒 | | | | | | TEL：　　　　－　　　　　－　　　　　　　　FAX：　　　　－　　　　　－ | | | | | | 交通機関 　線　　 駅より(所要時間)　　　　 分 | | | | | | ホームページのURL：  （※都老健ＨＰとリンク希望の方のみご記入下さい。） | | | | | | Ｅ-mailアドレス ： | | | | | | （ふりがな）  設置主体名称 | | ＊社会福祉法人の場合の事業種別（ 1.第2種社会福祉事業 2.公益事業 ） | | | | | | （ふりがな）  設置主体所在地 | | 〒 | | | | | | TEL：　　　　－　　　　　－　　　　　　　　FAX：　　　　－　　　　　－ | | | | | | （ふりがな）  指定管理者名称  ＊4参照 | | （＊公立等の施設で、医療法人等の他法人へ業務委託している場合にご記入して下さい。） | | | | | | （ふりがな）  指定管理者所在地 | | 〒 | | | | | | TEL：　　　　－　　　　　－　　　　　　　　FAX：　　　　－　　　　　－ | | | | | | 開設許可日 | | 年　　　月　　　日 | | 開　設　日 | | 年　　　月　　　日 |   ＊１ 必要事項を記入し､ブロック専任理事長印を受けてから協会事務局あて送付して下さい｡  ＊２ 法人概要・施設パンフレットを同封して下さい。  ＊３ 「設置主体」とは、介護保険法第９４条に定める「介護老人保健施設を開設した者」を指します。  ＊４ 地方自治法による指定管理者に業務を委託されている場合のみご記入下さい。 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | サテライト型小規模介護老人保健施設 | | | | ない　／　ある　（ある場合は所在地等を記載してください。） | | | | | | | | | | | | 施設名称 | |  | | | | | | | | | | | | | | （ふりがな）  施設所在地 | | 〒 | | | | | | | | | | | | | | TEL：　　　　－　　　　　－　　　　　　　　FAX：　　　　－　　　　　－ | | | | | | | | | | | | | | 本体施設からの距離 km　／　所要時間　　　　 分 | | | | | | | | | | | | | | 分館型介護老人保健施設 | | | | ない　／　ある　（ある場合は所在地等を記載してください。） | | | | | | | | | | | | 施設名称 | |  | | | | | | | | | | | | | | （ふりがな）  施設所在地 | | 〒 | | | | | | | | | | | | | | TEL：　　　　－　　　　　－　　　　　　　　FAX：　　　　－　　　　　－ | | | | | | | | | | | | | | 本体施設からの距離 km　／　所要時間　　　　 分 | | | | | | | | | | | | | | 定床数 | | 本体施設 | | | 床（うち認知症専門棟　　　　床） | | | | | | | | | 合計　　　　　床 | | サテライト型 | | | 床 | | | | | | | | | | 分館型 | | | 床 | | | | | | | | | | 通所リハビリテーション定員数 | | | | | 人 | | | | 訪問リハビリテーションの実施 | | | | | 有　・　無 | | （ふりがな）  開設者氏名 | |  | | | | 役職 |  | | | 職種 | | （　　　　　　）  ＊医師の場合は専門科目 | | | | （ふりがな）  施設長氏名 | |  | | | | 職種 |  | | | 専門科目 | | ＊医師の場合のみ | | | | （ふりがな）  管理者氏名 | |  | | | | 職種 |  | | | 専門科目 | | ＊医師の場合のみ | | | | （ふりがな）  事務担当者氏名 | |  | | | | 役職 |  | | | 職種 | | （　　　　　　）  ＊医師の場合は専門科目 | | | | 設置形態 | 1.独立　2.病院併設　3.診療所併設　4.介護老人福祉施設併設　5.病院･介護老人福祉施設併設  6.診療所･介護老人福祉施設併設　7.その他の施設との併設 | | | | | | | | | | | | | | | 病院 | | （名称） | | | | （診療科目） | | | | | | | | | 診療所 | | （名称） | | | | （診療科目） | | | | | | | | | 介護老人福祉施設 | | （名称） | | | | | その他 | | | （名称） | | | | | その他 | 国庫補助の有無 | | 有（　　　年度）　・　無 | | | | | | | | | | | | | 病床転換型老健 | | 病床転換型である （　　年度実施） 【療養型老健 ・ 従来型老健】　・　病床転換型でない | | | | | | | | | | | | | 新築･改築の別 及び建物の階数 | | 1.新築　2.一部新・改築(新床・改床)  　 階建 \*高層化･複合型の場合 　階部分 | | | | | | | | | | 同一都道府県内の同一人物 又は同一法人における2施設目 以降の老健の場合はチェック | | | 入会金の分納 | | 希望する　　・　　希望しない | | | | | | | | | | □ | | | 施設として特筆できる事項 | | |  | | | | | | | | | | | | | 備　考（サテライト型小規模介護老人保健施設が２以上ある場合等はこちらに付記してください。） | | | | | | | | | | | | | | | |