LONG TERM CARE OMBUDSMAN PROGRAM
MENTORING FORM for OMBUDSMAN REPRESENTATIVES

Name of Ombudsman Representative: _____

Name of Supervisor: _____

Name of Facility: _____

Introductory Visit **Date:** _____

Plan:

First Mentoring Visit with Supervisor **Date:** _____

Plan:

-Continued-

LONG TERM CARE OMBUDSMAN PROGRAM
MENTORING FORM for OMBUDSMAN REPRESENTATIVES

Second Mentoring Visit with Supervisor **Date: _____**

Plan:

Third Mentoring Visit with Supervisor **Date: _____**

Long Range Plan: