FOUR SEASONS
571 S. ALLEN ROAD,
FLAT ROCK, NC 28731

Fax: (828) 233-2594 – **Cover Sheet Required**
e-mail lwild@fourseasonscfl.org

___ Pt List
___ Vol. Coord.
___ Volgistics

VOLUNTEER CONTACT RECORD

Patient's Name_____ Patient ID #_____
(Volunteer: **Provide First Name only and do NOT provide Patient ID#; filled in by V.C.)**
Services Provided: (check all that apply)

County	**Setting**	**Plan of Care (POC)**
___ Buncombe ___ Haywood ___ Madison ___McDowell	___ Assisted Living (ALF) ___ Home Care (HC) ___ Nursing Home	_ Complementary Therapy_____ _ Errands _ Respite _ Socialization _ Transportation _ Write letters/Read/Music _ Other: _____

Date of Visit (1 month/sheet only!)	**Brief Narrative of Visit**	**Mileage** (Round Trip)	**Total Hours** (Include Travel Time)

ALL DOCUMENTATION IS DUE AT THE END OF THE MONTH

VOLUNTEER NAME:_____
(Please Print)

VOLUNTEER SIGNATURE: _____

Comments: _____

*Reviewed by Volunteer Coordinator:___Lori Wild*_____