___ Pt List
___ Volgistics
___ Vol Coord

FOUR SEASONS

571 South Allen Rd, Flat Rock, NC 28731

Fax: (828) 233-0351 – **Cover Sheet Required**

E-Mail: cgodwin@fourseasonscfl.org

VOLUNTEER CONTACT RECORD

Patient's Name_____ Patient ID #_____

(if e-mailing or faxing, include ONLY First Name of Patient)

Services Provided: (check all that apply)

County	**Setting**	**Plan of Care (POC)**	
☐ Jackson	☐ Home Care (HC)	☐ Errands	☐ Companionship
☐ Macon	☐ Nursing Home (NH)	☐ Respite	☐ Socialization
☐ Swain	☐ Assisted Living Facility (ALF)	☐ Pet Therapy	☐ Transportation
☐ Cherokee/Graham/Clay		☐ Complimentary	
		☐ 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:*_____

12/2022