EXTENSION REQUEST - NURSING HOME PROGRAM

This form must be completed in its entirety and faxed to (304) 558-2515.

Please type or print legibly

Facility Name: _____ (Do Not Abbreviate)

Alleged Victim Name: _____ **Date of Incident:** _____

Alleged Perpetrator Name: _____ **Position/Title**:_____
(Do Not Abbreviate)

Reason for extension request

Please state the reasons why the facility is unable to complete the investigation within the required time frame:

_____

_____

_____

_____

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_____

_____

How many additional days does the facility anticipate needing to complete the investigation? _____

Person Completing This Form: _____ **Position/Title:** _____

Telephone Number: _____ **Time for Contact:** _____

Signature: _____ **Date:** _____

THIS SECTION TO BE COMPLETED BY OHFLAC REVIEWER

☐ **Approved** ☐ **Denied**

Signature: _____ **Date:** _____

The Follow-up information must be submitted to OHFLAC on _____**(Date)**