**ACKNOWLEDGEMENT STATEMENT POLICY & PROCEDURE:**

**SMOKING RESIDENTS**

I have read and understand the Policy and Procedure regarding residents smoking at

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. \_\_\_\_\_\_\_\_\_\_

(Facility) (Initials)

I understand that the facility has been assessed for a safe smoking environment and that this area may be located inside or outside the facility. \_\_\_\_\_\_\_\_\_\_

(Initials)

I understand that the Interdisciplinary Team, including the physician, will assess such resident for level of safety while smoking. I also understand that the assessment may change in relation to resident’s condition. \_\_\_\_\_\_\_\_\_\_

(Initials)

I understand that the Interdisciplinary Team will determine smoking restrictions for each individual resident in regard to the amount of supervision/assistance needed, based on the above assessments.

\_\_\_\_\_\_\_\_\_\_

(Initials)

I understand that the Interdisciplinary Team will evaluate the resident’s ability to obtain and store smoking equipment safely. \_\_\_\_\_\_\_\_\_\_

(Initials)

I understand that smoking shall not be allowed in bed at any time, unless under direct supervision and approved by the Facility Administrator. \_\_\_\_\_\_\_\_\_\_

(Initials)

I understand that the facility will make periodic checks to determine if the resident who smokes has any smoking equipment that violates the facility’s smoking regulations. \_\_\_\_\_\_\_\_\_\_

(Initials)

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Resident / Responsible Party Date

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Facility Representative Date