



**Daniel P. McCoy**  
County Executive

**Mark S. Olsen**  
Executive Director

## Smoking Policy Review

I, \_\_\_\_\_ have been notified and understand that Shaker Place Rehabilitation and Nursing Center is a Smoke Free Facility and I agree to abide by the rules and regulations set forth in the policy. If I wish to smoke, I will be offered assistance to be transferred to a facility that allows Residents to smoke and/or smoking cessation assistance and counselling will be made available to me.

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Resident Signature

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Family/Designated Representative:

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Witness

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Title

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

