

ADMINISTRATOR AND/OR DIRECTOR OF NURSING CHANGE

This form is to be completed within one working day of a personnel change and forwarded via email to:
DHSR.NH.ADMandDON.CHANGES@dhhs.nc.gov

CMS Certification Number (CCN): _____

Facility Name: _____

Facility Phone Number: () - _____ - _____

I. Administration

Name of previous Administrator: _____

Name of the new Administrator: _____
Full First Name Middle Initial Last Name Suffix

Date Hired as Administrator: _____ - _____ - _____

N.C. License Number: _____

Email Address of Administrator: _____

II. Nursing

Name of previous Director of Nursing: _____

Name of the new Director of Nursing: _____
Full First Name Middle Initial Last Name Suffix

Date Hired as D.O.N.: _____ - _____ - _____

License Number: _____

III. Personnel Name Change

Please use this section to notify DHHS of individual name change (Example: due to marriage)

Administrator D.O.N.

Former Name: _____

Current Name: _____
Full First Name Middle Initial Last Name Suffix