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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-02535 (08/2019) | **STATE OF WISCONSIN**Wis. Admin. Code § DHS 132.41(4)(d) |
| **NURSING HOME** **NOTICE OF CHANGE FOR ADMINISTRATOR OR DIRECTOR OF NURSING** |
| **INSTRUCTIONS** |
| * Use this form to notify the Division of Quality Assurance **within two working days of the change**.
* Complete all sections, sign, and submit this form via email to Elizabeth Laubenstein at: Elizabeth.Laubenstein@dhs.wisconsin.gov
* Direct any questions regarding this form to Elizabeth Laubenstein at 608-266-2966.
 |
| Type of Change: [ ]  Administrator [ ]  Director of Nursing  |
| **FACILITY INFORMATION** |
| Name – Facility       | License No.      |
| Name – Person Completing Form      | Title – Person Completing Form      |
| Telephone No.      | Email Address      |
| **PREVIOUS ADMINISTRATOR OR DIRECTOR OF NURSING** |
| Name – Previous Administrator / DON      | License No.      | Date – Left Position *(MM/dd/yyyy)*      |
| **NEW ADMINISTRATOR OR DIRECTOR OF NURSING** |
| Name – New Administrator / DON      | License No.      | Date – Began Position *(MM/dd/yyyy)*      |
| Work Status[ ]  Interim [ ]  Permanent [ ]  Acting (Unlicensed)\*  |
| **\*IF UNLICENSED, AN INDIVIDUAL HAS 120 DAYS TO OBTAIN A LICENSE.** **DQA MUST BE NOTIFIED OF THIS CHANGE WITHIN TWO WORKING DAYS.** |
| [ ]  Yes [ ]  No  | **Is this person authorized to accept personal service and receive registered and certified mail?** [Wis. Stat. § 50.03(2m)] |
| **SIGNATURE** – Person Completing Form | Date Signed *(MM/dd/yyyy)*      | Date Submitted *(MM/dd/yyyy)*      |