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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-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](mailto: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)* | |