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

Nursing Home License Number:  NH0____
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: _________
NCID User Name_________ This information is needed to associate the Nursing Home Administrator with the facility in Enterprise.

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