|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Department of Health Services**  Division of Quality Assurance  F-02535 (02/2025) | | | | **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 the Bureau of Nursing Home Resident Care at: [dhsdqabnhrclicensing@dhs.wisconsin.gov](mailto:dhsdqabnhrclicensing@dhs.wisconsin.gov) * Direct any questions regarding this form to [dhsdqabnhrclicensing@dhs.wisconsin.gov](mailto:dhsdqabnhrclicensing@dhs.wisconsin.gov). | | | | | | | | |
| Type of change:  Administrator  Director of Nursing | | | | | | | | |
| **Facility information** | | | | | | | | |
| Name – Facility | | | | | | | | License number |
| Name – Person completing form | | | | Title – Person completing form | | | | |
| Phone number | | Email address | | | | | | |
| **Previous administrator or director of nursing** | | | | | | | | |
| Name – Previous administrator/DON | | | License number | | | Date – Left position (MM/dd/yyyy) | | |
| **New administrator or director of nursing** | | | | | | | | |
| Name – New administrator/DON | | | License number | | | Date – Began position (MM/dd/yyyy) | | |
| Email address – New administrator/DON | | | | | | | | |
| 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) | |