SAVE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SECTION FOR LONG-TERM CARE REGULATION

CHANGE OF DIRECTOR OF NURSING IN A LONG-TERM CARE FACILITY

FACILITY INFORMATION

Name of Facility

Facility Address | City | Zip

Skilled Nursing Facility ☐ Intermediate Care Facility ☐

DIRECTOR OF NURSING INFORMATION

Name of the Director of Nursing	Effective Date of Change:
RN License Number	State Issued

Please provide contact information other than the Long-Term Care Facility Telephone Number:

Telephone Number | E-Mail Address

Cell Phone Number | Other Emergency Number

Name of previous Director of Nursing:

Last date of employment as Director of Nursing in this facility:

AFFIDAVIT

I attest by my signature that the statements contained in this form are true and correct to the best of my knowledge and belief. I further affirm that I have the express authority to sign this form on behalf of the operator.

Authorized Signature	Date
Printed or Typed Name	Title of Signatory

PLEASE RETURN THIS COMPLETED FORM BY MAIL, FAX OR E-MAIL:

DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR LONG-TERM CARE REGULATION
LICENSURE UNIT
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P.O. BOX 570
JEFFERSON CITY, MO 65102

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E-MAIL ADDRESS: LTCAPPLICATION@HEALTH.MO.GOV