



CHARLIE CRIST  
GOVERNOR

ANDREW C. AGWUNOBI, M.D.  
SECRETARY

### NOTIFICATION OF CHANGE OF ADMINISTRATOR

\_\_\_\_\_  
Name of Assisted Living Facility                      License #                      (\_\_\_\_) Telephone

\_\_\_\_\_  
Facility Street Address                      City                      County                      Zip Code

\_\_\_\_\_  
Signature of Owner/Authorized Agent

\_\_\_\_\_  
Date

Please provide the following information for the person to be designated as administrator:

Effective Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

The Agency for Health Care Administration is required to obtain your social security number pursuant to section 429.11(3), Florida Statutes. Disclosure of your social security number is mandatory. Your social security number will be used to secure the proper identification of the person listed on this notification.

Mailing Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Do you have a high school diploma ?  Yes  No  G.E.D.?

Are you a licensed nursing home administrator pursuant to part II of chapter 468, F.S.?  
 Yes  No                      License Number: \_\_\_\_\_.

Will you be serving as the administrator of more than this ALF ?  Yes  No.

[Note: An administrator may manage a maximum of 3 ALFs.]

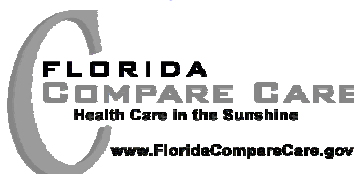
Name of Facility: \_\_\_\_\_ License Number: \_\_\_\_\_

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AHCA Form 3180-1006, Jan. 06

AHCA ALU, 2727 Mahan Drive, MS 30, Tallahassee, FL 32308 (850) 487-2515 Fax: (850) 410-1476  
Form available at: [http://ahca.myflorida.com/MCHQ/Long\\_Term\\_Care/Assisted\\_living/alf.shtml](http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/alf.shtml)

\_\_\_\_\_  
2727 Mahan Drive, MS#30  
Tallahassee, Florida 32308



\_\_\_\_\_  
Visit AHCA online at  
<http://ahca.myflorida.com>

**Affiliations** - Please list the name(s) of any entity licensed by this state or another state to provide health or residential care with which the administrator has been affiliated through ownership or employment within the last 5 years. [Attach additional sheets if necessary.]

Name & Type of Facility/Service Entity: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of Affiliation: \_\_\_\_\_ Employee? \_\_\_ Owner? \_\_\_ If owner, % of ownership? \_\_\_\_\_

If the entity has closed or ceased to operate due to financial problems; had a receiver appointed; had its license denied, suspended, or revoked; was subject to a moratorium on admissions; or had an injunctive proceeding initiated against it, please provide a detailed description and explanation of the occurrence. [Attach additional sheets if necessary.]

Adverse Action: \_\_\_ Yes? \_\_\_ No? If yes, description, explanation, and date of occurrence \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**References** - Please provide two references of whom the agency may inquire as to the administrator's character, reputation, and financial responsibility:

Name	Address	Phone
_____	_____	_____
_____	_____	_____

**Background Screening** - Pursuant to § 429.174, F.S., and rule 58A-5.019, F.A.C., all facility administrators are subject to Level 2 background screening. Please attach required screening form and fee.