



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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