AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA)

Personnel Change

Information form • www.pnsystem.com

☐ **$225.00**
PD or Medicare Agencies

Do not print or scan this form. Save it to your computer, type the information using Adobe Reader, and then email it to us.
Use proper capitalization: capitalize the first letter of names, streets and cities, then use lower case.

1 POSITION CHANGE

Select position: ☐ DON ☐ Administrator ☐ Alt. Administrator ☐ Alt. DON **Effective Date:** _____

☐ Other (title): _____ *(different from above, e.g., CFO)*

** The person must qualify and cannot hold an executive position anywhere else.*

2 AGENCY INFORMATION

Agency: _____

License #: _____ **NPI:** _____ **MC #:** _____ **MA #:** _____

License Issue Date: _____ **Exp. Date:** _____ **Medicare # Issue Date:** _____

Address: _____

Phone: _____ **Fax:** _____ **Tax ID:** _____

Email: _____ **Contact Person:** _____

Administrator Name: _____

Incorporation Date: _____ **Accreditation Body:** _____ **Date:** _____ **Exp.:** _____

AHCA User: _____ **Password:** _____ **PECOS User:** _____ **Password:** _____

3 NEW PERSON

New: ☐ DON ☐ Administrator ☐ Alt. Administrator ☐ Alt. DON

Name: _____ **Lic #:** _____ **Email:** _____

Home Address: _____

☐ Full Time ☐ Part Time **DOB:** _____ **Phone:** _____

SS #: _____ **% Interest:** _____ **% Ownership Interest:** _____ ☐ N/A

Born (State/Province): _____ **Country:** _____ **Last Criminal Background Check:** _____

Add to the staff record: resume (1–2 years of supervisory experience), copy of license, and a letter stating the change date.
Do not email these to us. Complete orientation in the new position.

4 PREVIOUS PERSON (BEING REPLACED)

Old: ☐ DON ☐ Administrator ☐ Alt. Administrator ☐ Alt. DON

Name: _____ **Delete Date:** _____ **SS #:** _____

DOB: _____ **Born (State/Province):** _____ **Country:** _____

5 CLIA AND HOURS OF OPERATION

CLIA #: _____ **Hours of Operation:** _____ am to _____ pm

Agency Glucometer (brand/model): _____

Test Strips (brand/model): _____ **Lancets (brand/model):** _____

6 LICENSE NUMBERS (ANY CHANGES)

DON Lic #: _____ **Alt. DON Lic #:** _____ **Admin. Lic #:** _____ **Alt. Admin. Lic #:** _____

(Administrator license numbers, if applicable)

• **Remember to update the information in the Clearinghouse.**

Save this document, type the information using Adobe Reader, and then email it to us.

Email Form