



TEMPORARY NURSING SERVICE AGENCY

CHANGE OF LOCATION

To change the location of a registered Temporary Nursing Service Agency, complete this form. Use a separate form for each office to be relocated. The fee for each site relocation is \$100.00. Submit the form with a check, payable to "Commonwealth of Massachusetts," to:

Pearlina Mills, Program Coordinator
Department of Public Health, Division of Health Care Facility Licensure and Certification
99 Chauncy Street, 2nd Floor
Boston, MA 02111

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1. Agency Registration Number _____
 2. _____
Agency Name
 3. _____
Office address prior to move
 4. _____
Office address after move
 5. New Telephone numbers _____
Voice _____ Fax _____
 6. Start date for new address _____ / _____ / _____
mm dd yyyy
 7. Check number _____ in the amount of: \$100.00, enclosed.

Signed: _____
 Print Name _____ Print Title _____

 Signature _____ Date _____

For DPH Use Only: Received: ___ / ___ / ___

Move Confirmed Effective As Of: ___ / ___ / ___ Entered on FMF: ___ / ___ / ___

Comments: _____

Copy & check to Survey Processing: ___ / ___ / ___