DEPARTMENT OF HEALTH

# Change of Director of Nursing (DON)

## Complete all the following information.

Health Facility Identification Number (HFID)/OpenGov ID: _____

CMS Certification Number (CCN), if applicable: _____

Facility name (doing business as): _____

Facility address: _____

Name of previous Director of Nursing: _____

Name of new Director of Nursing: _____

Direct Email Address: _____

Direct Phone Number: _____

Effective date of change: _____

## Next Steps

- Email completed form to health.hrd-fedlcr@state.mn.us

## Affirmation

☐ I certify that the information provided on this form is accurate and complete.

Signature of Authorized Representative/DON: _____

Name (print or type): _____

Title: _____

Date: _____

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4200
Health.HRD-FedLCR@state.mn.us

06/16/2025

*If you have questions, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.*