Surgical Center - Change of Administrator

Complete all the following information.

Health Facility Identification Number (HFID): _____

CMS Certification Number (CCN) (if applicable): _____

Surgical Center Doing Business As (DBA) name: _____

Surgical Center address: _____

Name of previous Administrator: _____

Name of new Administrator: _____

Direct Email Address: _____

Direct Phone Number: _____

Effective date of change: _____

Next Steps for Surgical Center

- Email form to health.hrd-fedlcr@state.mn.us.
- If deemed status, notify the accrediting organization (if applicable).

Affirmation

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

Signature of Administrator/Authorized Agent: _____

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

10/30/2026

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