STATE OF IOWA DEPARTMENT OF

Health AND Human SERVICES

Bureau of Radiological Health

Notice of Change Form

Type of Change:

- ❑ Ownership
- ❑ New Authorized Representative
- ❑ New Address
- ❑ Facility Name Change
- ❑ Facility Relocation

Type of Facility:

- ❑ Dental
- ❑ Veterinary
- ❑ Podiatry
- ❑ Medical / Chiropractic
- ❑ Service Provider

Date of Change:	

Current / Past Facility Information	***New / Future Facility Information***
Name	Name
Street	Street
City State Zip	City State Zip
Telephone	Telephone
IDPH Registration #	IDPH Registration #
EIN	EIN
Current Authorized Representative	***New Authorized Representative***
Contact Person	Contact Person
Telephone	Telephone
Email	Email
Email all correspondence to	

***Mailing to Address*:**
Iowa Department of Health and Human Services
Bureau of Radiological Health
Lucas State Office Building, 5th Floor
321 East 12th ST
Des Moines, IA 50319

Email to Address:
radhealthia@idph.iowa.gov

My signature on this form affirms that the information I have provided on this request is true and accurate. I have truthfully represented my facility in this change of ownership request.

_____ _____
Signature Date

_____
Please Print Your Name Clearly