

Bureau of Radiological Health Notice of Change Form

Type of Change:

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

Type of Facility:

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

<i>Date of Change:</i>	
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<i>Current / Past Facility Information</i>	<i>New / Future Facility Information</i>
Name	Name
Street	Street
City State Zip	City State Zip
Telephone	Telephone
IDPH Registration #	IDPH Registration #
EIN	EIN
<i>Current Authorized Representative</i>	<i>New Authorized Representative</i>
Contact Person	Contact Person
Telephone	Telephone
Email	Email
Email all correspondence to	

Mailing to Address:

Iowa Department of Public Health
 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