

Massachusetts Department of Public Health

Bureau of Substance Abuse Services / Office of Quality Assurance and Licensing

KEY PERSONNEL CHANGE REPORTING FORM

Please fax completed form (no cover sheet is necessary) to QAAL secure fax: 617-624-5395

**KEY PERSONNEL CHANGE**

Please notify DPH/BSAS at least **two weeks** before a planned change or within **two business days** of an unplanned change of the following key personnel (please check one, and **ATTACH RESUME of replacement/interim/**

Reporter Name/Title: \_\_\_\_\_

Program Name: \_\_\_\_\_

License #: \_\_\_\_\_

Address: \_\_\_\_\_

If interim, please submit a projected timeline for replacing the staff member:

- Medical Director,  Program Director,  Clinical Director  Clinical Supervisor
- Compliance Officer,  Nurse Manager,  Executive Director  License Administrator,
- Senior Management (Responsible for program oversight)

Name of Person Leaving: \_\_\_\_\_

Last Day: \_\_\_\_\_

Replacement (**Permanent**): \_\_\_\_\_

Replacement Start Date: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**OR**

**Interim Replacement** (& Projected start date of replacement): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Resume of Replacement /Interim**

**If Interim Please Submit a Coverage Plan**