TEMPORARY NURSING SERVICE AGENCY

**Change of Location**

To change the location of a registered Temporary Nursing Service Agency, complete this form. Use a separate form for each office to be relocated. The fee for each site relocation is $100.00. Submit the form with a check, payable to "Commonwealth of Massachusetts," to:

Licensure Coordinator

Department of Public Health
Division of Health Care Facility Licensure and Certification

67 Forest Street

Marlborough, MA 01752

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| --- |
|  |

1. Agency Registration Number

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Name

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office address prior to move

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office address after move

5. New Telephone numbers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Voice Fax

6. Start date for new address \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

 mm dd yyyy

7. Check number \_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the amount of: $100.00, enclosed.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Print Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**For DPH Use Only:** Received: \_\_\_ /\_\_\_ /\_\_\_

Move Confirmed Effective As Of: \_\_\_ /\_\_\_ /\_\_\_ Entered on FMF: \_\_\_ /\_\_\_ /\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copy & check to Survey Processing: \_\_\_ /\_\_\_ /\_\_\_