

NHA/FACILITY PROFILE SHEET

PLEASE PRINT CLEARLY IN INK OR TYPE

Please complete and return profile sheet to NHAP at address listed below within 30 days of change(s).

NAME OF ADMINISTRATOR	NHA LICENSE NO.
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SECTION I

FACILITY EMPLOYMENT INFORMATION

DATES		EMPLOYED	NAME OF NURSING HOME	ADDRESS OF NURSING HOME
FROM	TO			
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION II

CHANGE OF ADDRESS INFORMATION

LAST NAME	FIRST NAME		MIDDLE NAME
ADDRESS	CITY	STATE	ZIP CODE
NHA LICENSE NUMBER	TELEPHONE NUMBER	SOCIAL SECURITY NUMBER	EFF. DATE OF CHANGE

OLD ADDRESS INFORMATION

ADDRESS	CITY	STATE	ZIP CODE
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SECTION III

NAME CHANGE – (Attach appropriate documentation verifying the change (e.g., copy of driver’s license, marriage license, passport, etc.))

LAST NAME	FIRST NAME		MIDDLE NAME
ADDRESS	CITY	STATE	ZIP CODE
NHA LICENSE NUMBER	TELEPHONE NUMBER (HOME)	TELEPHONE NUMBER (BUSINESS)	

I certify under the penalty of perjury laws of the State of California that the information obtained in this document is both true and correct.

Signature of Administrator *Date*

FOR OFFICE USE ONLY
DATE RECEIVED _____ NHAP STAFF _____
DATE UPDATED & FILED _____