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