


NF38 Form	Health Information and Quality Authority Change of Contact Person, or Provider Nominee	 Health Information and Quality Authority <small>An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte</small>
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Section 1. Designated centre details		For official use
Centre name		<input type="checkbox"/>
Centre ID (OSV)		<input type="checkbox"/>
Registered provider name		<input type="checkbox"/>
Please state the reason for this notification. Please tick the relevant box or boxes and complete the associated section (s).		
Section 2.	Change of contact person . <input type="checkbox"/>	<input type="checkbox"/>
Section 3.	Change of provider nominee . <input type="checkbox"/>	<input type="checkbox"/>

Section 2. Contact person*				For official use
Name of outgoing person				<input type="checkbox"/>
Name of the new person	Title	First name	Surname	<input type="checkbox"/>
Role in relation to the designated centre.				<input type="checkbox"/>
Business address				<input type="checkbox"/>
Eircode				<input type="checkbox"/>
Business phone number (during office hours)				<input type="checkbox"/>
Business mobile number (optional)				<input type="checkbox"/>
Business email address				<input type="checkbox"/>
Date the change will take effect				<input type="checkbox"/>

* Please read our guidance, for a definition of the "contact person". Our guidance is available to download from our website's [registration resource centre](#).

Section 3. Change of provider nominee				For official use
Name of outgoing person				<input type="checkbox"/>
Name of the new person	Title	First name	Surname	<input type="checkbox"/>
Role in relation to the designated centre.				<input type="checkbox"/>
Business address				<input type="checkbox"/>
Eircode				<input type="checkbox"/>
Business phone number (during office hours)				<input type="checkbox"/>
Business mobile number (optional)				<input type="checkbox"/>
Business email address				<input type="checkbox"/>
Date the change will take effect				<input type="checkbox"/>

Section 4. Declaration by the registered provider		For official use
I, the undersigned, declare that the information I have provided in this notification form is true to the best of my knowledge and belief.		
Name (print)		<input type="checkbox"/>
Position	Director <input type="checkbox"/> Partner <input type="checkbox"/> Committee/board member <input type="checkbox"/> Individual/sole trader <input type="checkbox"/> Person responsible on behalf of the statutory body <input type="checkbox"/> Authorised person <input type="checkbox"/>	<input type="checkbox"/>
Signed		<input type="checkbox"/>
Date		<input type="checkbox"/>
Contact number (during office hours)		<input type="checkbox"/>

Please return the completed form to:

Registration Office, Health Information and Quality Authority, Unit 1301, City Gate,
Mahon, Cork, T12 Y2XT.

Telephone no: 021 240 9340

Email: registration@hiqa.ie