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| NF301 | <h2 style="margin: 0;">Notification Form</h2> <h3 style="margin: 0;">Change of Stakeholder Details</h3> <p style="margin: 10px 0 0 0; color: #0070C0;">To be completed in conjunction with 'The Guide to Monitoring IPAS' document available at www.hiqa.ie</p> |  <p style="margin: 0;">Health Information and Quality Authority <small>An tUdarás Um Fhaisnéis agus Cáilíocht Sláinte</small></p> |
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| Please indicate the type of change required (tick relevant option) | | |
|--|--|--------------------------------------|
| Change of provider details | | Proceed to Section 1 |
| Change of provider representative details | | Proceed to Section 2 |
| Change of centre manager details | | Proceed to Section 3 |

| Section 1. Change of provider details | | | | |
|--|----------------------|---------------------|------------------------------|------------------|
| | Original information | Updated information | Date change will take effect | For official use |
| Service Provider name | | | | |
| Service Provider address | Address line 1 | | | |
| | Address line 2 | | | |
| | Address line 3 | | | |
| | County | | | |
| | Country | | | |
| | Eircode | | | |
| Service Provider email address | | | | |
| Service Provider contact number | | | | |
| Service Provider website | | | | |

[If this is the only change, proceed to Section 4](#)

Section 2. Change of provider representative details

If there is a new provider representative, please complete Section 2a. If you are updating the contact details for the current provider representative, please complete Section 2b.

| Section 2a. Change of provider representative person | | | | | Date change will take effect | For official use |
|--|--|---|---|-----------|------------------------------|------------------|
| Departing provider representative name | | Has a new person been appointed to be the provider representative? | | | | |
| | | Yes | | No | | |
| New provider representative name | New provider representative job title | New provider representative email address | New provider representative contact number | | | |
| | | | | | | |

| Section 2b. Change of contact details of current provider representative | | | | Date change will take effect | For official use |
|--|--|--|---|------------------------------|------------------|
| Provider representative name | Provider representative new job title | Provider representative new email address | Provider representative new contact number | | |
| | | | | | |

[If this is the only change, proceed to Section 4](#)

Section 3. Change of centre manager details

If there is a new centre manager, please complete Section 3a. If you are updating the contact details for the current centre manager, please complete Section 3b.

| Section 3a. Change of centre manager | | | | | Date change will take effect | For official use |
|--------------------------------------|------------------------------|--|----|-----------------------------------|------------------------------|------------------|
| Departing centre manager name | | Has a new person been appointed to be the centre manager? | | | | |
| | | Yes | No | | | |
| New centre manager name | New centre manager job title | New centre manager email address | | New centre manager contact number | | |
| | | | | | | |

| Section 3b. Change of contact details of current centre manager | | | | Date change will take effect | For official use |
|---|------------------------------|----------------------------------|-----------------------------------|------------------------------|------------------|
| Centre manager name | Centre manager new job title | Centre manager new email address | Centre manager new contact number | | |
| | | | | | |

[Proceed to Section 4](#)

| Section 4. Declaration | | | For official use |
|--|--|--|------------------|
| I, the undersigned, declare as the Service Provider/authorised on behalf of the Service Provider that the information I have provided in this notification form is true to the best of my knowledge and belief. | | | |
| Signed by (select as appropriate) | Sole trader | | |
| | Partner of the partnership | | |
| | Director of the company | | |
| | Member of the committee of management or other controlling authority of an unincorporated body | | |
| | Member of the board, directorate or other governance structure of the statutory body or body corporate | | |
| Name | | | |
| Job title | | | |
| Signature | | | |
| Date | | | |

Please return the completed, signed form by email to ipasmonitoring@hiqa.ie

Please ensure **NF301 is clearly stated in the subject bar of the email**