Change of Medical Director

Complete all the following information.

Health Facility Identification Number (HFID)/OpenGov ID: _____

CMS Certification Number (CCN), if applicable: _____

Facility name (doing business as): _____

Facility address: _____

Name of previous Medical Director: _____

Name of new Medical Director: _____

Direct Email Address: _____

Direct Phone Number: _____

Effective date of change: _____

Next Steps

- Email completed form to health.hrd-fedlcr@state.mn.us

Affirmation

☐ I certify that the information provided on this form is accurate and complete.

Signature of Authorized Representative/DON: _____

Name (print or type): _____

Title: _____

Date: _____

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4200
Health.HRD-FedLCR@state.mn.us

06/16/2025

If you have questions, please email Health.HRD-FedLCR@state.mn.us or call 651-201-4200.