

Nursing Facility Administrator Program
Data Change/Duplicate License Request

I request the Department of Aging and Disability Services update licensure information for the following reason(s).

Please check the appropriate box.

| | | | |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> Name Change | <input type="checkbox"/> Address Change | <input type="checkbox"/> Employment Change | <input type="checkbox"/> Duplicate License/Renewal Card (include cashier's check or money order for \$25 fee) |
|--------------------------------------|---|--|--|

Name Change – Attach a legible photocopy of a picture identification that shows your birth date and the correct spelling of your name. You must also submit a copy of the marriage license, divorce decree or other order detailing a name change.

| | | | |
|-------------------------------|----------------------------|-------|--------|
| Name (as currently listed) | Last | First | Middle |
| Name Change | Last | First | Middle |
| License Number | Date of Birth (mm/dd/yyyy) | | |

Duplicate License/Renewal Card Fee – \$25

| | | | |
|--|---------------------------------|---|-----------------------------|
| <input type="checkbox"/> Duplicate License <input type="checkbox"/> Lost <input type="checkbox"/> Stolen <input type="checkbox"/> Destroyed | | <input type="checkbox"/> Duplicate Renewal Card <input type="checkbox"/> Lost <input type="checkbox"/> Stolen <input type="checkbox"/> Destroyed | |
| New Home Address | (Street, P.O. Box, Rural, etc.) | | New Telephone No. () |
| | City | State | ZIP Code |

Employment Address Change

| | | | |
|------------------------|---------------------------------|-------|-----------------------------|
| New Employment Address | Facility Name | | |
| | (Street, P.O. Box, Rural, etc.) | | New Telephone No. () |
| | City | State | ZIP Code |

TO THE STATE OF _____)
COUNTY OF _____)

Before me, a Notary Public, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he or she executed the same for the purpose and consideration therein expressed.

Given under my hand and seal of office, this _____ day of _____, 20 _____.

Signature – Notary Public, State of Texas

Printed Name – Notary Public

Date Commission Expires

**Place notary seal
or stamp here.**

Mail this form to:
Department of Aging and Disability Services
Nursing Facility Administrator Program
P.O. Box 149030
Mail Code E-420
Austin, Texas 78714-9030

credential@dads.state.tx.us

With a few exceptions, you have the right to request and be informed about the information that the Department of Aging and Disability Services (DADS) obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask DADS to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, please contact the Long Term Care Nursing Facility Administrator Program at 512-438-2015.