

PROFILE SHEET

Please provide your name, license number (if one has been issued) and contact information, then complete only the sections below that apply. Submit the signed and completed form to NHAP within thirty (30) days of change(s):

NAME	NHA/AIT/PROVISIONAL NUMBER
EMAIL ADDRESS	PHONE NUMBER

SECTION I

FACILITY EMPLOYMENT INFORMATION

DATE FROM	DATE TO	EMPLOYED	NAME OF NURSING HOME	ADDRESS OF NURSING HOME
		Yes No		
		Yes No		
		Yes No		

SECTION II

CHANGE OF ADDRESS INFORMATION

PUBLIC ADDRESS (REQUIRED) - Subject to Public Records Act Request Release*	(City)	(State)	(Zip Code)
CONFIDENTIAL ADDRESS (FOR CDPH USE ONLY**)	(City)	(State)	(Zip Code)

* Pursuant to a court order, the California Department of Public Health will be required to release the address of record for certified nurse assistants, home health aides, certified hemodialysis technicians, and licensed nursing home administrators in response to a Public Records Act request. (Government Code starting at section 6250.) Court Order: *Service Employees International Union-United Healthcare Workers v. California Department of Public Health*, Sacramento County Superior Court, February 21, 2018, No. 34-2017-80002636.

** If the confidential address section is left blank, all departmental mail will be sent to the public address.

SECTION III

NAME CHANGE - (Attach appropriate documentation verifying the change (e.g. copy of driver's license, marriage license, passport, etc.)

NHA's NEW NAME (Last)	(First)	(Middle)
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Maintenance of the information requested on this form is required by Section 1416.34(h) and Section 1416.60 of the Health and Safety Code. No items of information are voluntary; failure to provide any of the required information may result in a citation being issued.

I certify under the penalty of perjury under applicable state and federal laws that the information contained in this application and supporting documents, is true and correct. I further understand that any false, incomplete, or incorrect statements may result in denial of this application.

Signature

Date

FOR OFFICE USE ONLY

NHAP STAFF INITIALS	_____
DATE RECEIVED	_____
DATE UPDATED AND FILED	_____