

REPORT OF CHANGE IN INFORMATION FOR APPROVED SCHOOLS

INSTRUCTIONS: Complete School Information and Effective Date of Change. Then complete only sections for which a change has occurred. Attach supporting documentation as indicated.

School Information and Effective Date of Change	
Name of School	School ID
Effective Date of Change	

Change in School Information (Complete only applicable fields. Do not use this form for change of ownership.)		
New Name of School		
New Street Address	City	ZIP Code
New Mailing Address	City	ZIP Code
New Telephone Number	New E-mail Address	

Change in Program Director or Clinical Coordinator Information	
<input type="checkbox"/> New Program Director or Clinical Coordinator. Attach documentation to indicate that each new faculty member meets the qualification requirements of 17 CCR, section 30418.	
Name	Title
Phone Number	E-mail Address
<input type="checkbox"/> Removing current Program Director or Clinical Coordinator	
Name	Title
Phone Number	E-mail Address
<input type="checkbox"/> Change in information for current Program Director or Clinical Coordinator	
Name	Title
Phone Number	E-mail Address

Change in JRCERT accreditation status (Joint Review Committee on Education in Radiologic Technology)
<input type="checkbox"/> Initial JRCERT accreditation received, effective date:
<input type="checkbox"/> JRCERT accreditation withdrawn, effective date:

Change in Course Offerings or Curricula (Only if the new curricula no longer meets the applicable regulations)
<input type="checkbox"/> Changes to current courses. Attach course descriptions and hours.

Discontinuance of a school
<input type="checkbox"/> The school’s approval certificate is attached and is being returned to the Department.
<input type="checkbox"/> Documentation is attached to inform the Department how the record retention requirements of 17 CCR, section 30437(b) will be met.

By my signature below, I declare that the information submitted on this form and its attachments is true and correct.

Name of Designated School Official (print clearly)	Title
Signature of Designated School Official	Date

Mail completed form and supporting documentation to either address below:

Express Mail:
CDPH - Radiologic Health Branch
Certification Unit, MS 7610
1500 Capitol Avenue
Sacramento, CA 95814-5006

Or

Mailing Address:
CDPH - Radiologic Health Branch
Certification Unit, MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414