

**Bureau of Radiological Health Notice of Change Form**

**Type of Change:**

- Ownership
- New Authorized Representative
- New Address
- Facility Name Change

**Type of Facility:**

- Dental
- Veterinary
- Podiatry
- Medical / Chiropractic
- Service Provider

<b><i>Date of Ownership Change:</i></b>	
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<b><i>Current / Past Facility Information</i></b>	<b><i>New / Future Facility Information</i></b>
Name	Name
Street	Street
City State Zip	City State Zip
Telephone	Telephone
IDPH Registration #	IDPH Registration #
EIN	EIN
<b><i>Current Authorized Representative</i></b>	<b><i>New Authorized Representative</i></b>
Contact Person	Contact Person
Telephone	Telephone
Email	Email
Email all correspondence to	

***Mailing to Address:***

Iowa Department of Public Health  
 Bureau of Radiological Health  
 Lucas State Office Building, 5th Floor  
 321 East 12th ST  
 Des Moines, IA 50319

**Email to Address:**

**radhealthia@idph.iowa.gov**

My signature on this form affirms that the information I have provided on this request is true and accurate. I have truthfully represented my facility in this change of ownership request.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Your Name Clearly