



FACILITY NAME AND OWNERSHIP CHANGE FORM

Submit this Form by E-Mail

Check appropriate box(es):

My Facility has a New Name

My Facility has a New Owner

Old Facility Name: _____

New Facility Name: _____

Old Facility Owner: _____

New Facility Owner: _____

Effective Date of change: ____/____/____

Facility ID # (FIN): _____
(CoC Cancer Program ID number)

Federal Employer ID # (FEIN): _____
(Federal Tax ID number)

Name of Cancer Program Administrator
(or other Official approving this change)

Title

Facility Address: _____
(Street Address) (City) (State) (Zip Code)

Name of Person Completing Form

Title

Your Telephone #: _____

Your Email Address: _____

Comments: