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| HealthCert | **Notification of change offacility manager** |  |

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| **1. Premises** |
| Legal entity name |
| Enter legal entity name. |
|  Facility name |
| Enter facility name. |
| District |
| Enter the district the facility is in. |
| **2. Facility manager’s details** |
| Title |  | First name(s) |  | Last name |
| Enter title. |  | Enter first name(s). |  | Enter last name. |
| Phone number |  | Mobile number |
| Enter phone number. |  | Enter mobile number. |
| Email address |
| Enter the new facility manager email address. |
| Is the facility manager the legal entity contact? |
| Please choose an item. |
| Start date for new facility manager |  | Name and finish date for previous facility manager |
| Enter the new facility manager’s start date. |  | Enter the name and finish date of the previous facility manager. |
| Is the appointment temporary or permanent? |
| Choose an item. |
| Is the facility manager also the clinical manager? (If yes please also complete a change of clinical manager form) |
| Choose an item. |
| Does the new facility manager manage more than one aged care facility? |
| Choose an item. |
| If yes, please name the facility |
| Enter facility name. |
| Has Te Whatu Ora been notified of this appointment? |
| Choose an item. |

**State whether the new facility manager meets the following requirements**

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| The person holds a current qualification or has experience relevant to both management and the health and personal care of older people, plans in place to attend to at least eight hours annually of professional development activities related to managing a rest home.[[1]](#footnote-2) | Choose an item. |
| The person’s role includes, but is not limited to, ensuring the residents of the premises are adequately care for in respect to their everyday needs.[[2]](#footnote-3) | Choose an item. |
| The person’s services provided to residents are consistent with obligations under legislation and the terms of the Aged Related Residential Care Agreement.[[3]](#footnote-4) | Choose an item. |

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| **3. Declaration** |

I declare that the information provided is true and correct and I have the designated authority to make this notification.

|  |  |  |
| --- | --- | --- |
| Name |  | Date |
| Enter your name. |  | Enter date. |
| Designation |
| Enter your designation. |

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| **4. Submitting form** |

Please email the completed form to certification@health.govt.nz

If you have any questions, please contact HealthCERT on 0800 113 813.

If you hold a contract with Te Whatu Ora, you should also send a copy of this form to your Te Whatu Ora Portfolio Manager.

1. Refer Aged Related Residential Care Agreement clause D17.3(d)(i). [↑](#footnote-ref-2)
2. Refer Aged Related Residential Care Agreement clause D17.3(d)(ii). [↑](#footnote-ref-3)
3. Refer Aged Related Residential Care Agreement clause D17.3(d)(ii) and the Health and Disability Services Standards 2008, standard 1.2.1. [↑](#footnote-ref-4)