

NF400B

## Notification Form

Service Provider Directory Form for Publically Funded Acute and Community Hospitals

To be completed in conjunction with guidance published at [www.higa.ie](http://www.higa.ie)



### Section 1. Hospital service provider details

Hospital service provider <b>name</b>		
Hospital service provider <b>address</b>	Address line 1	
	Address line 2	
	County	
	Eircode	
Hospital service provider <b>email address</b>		
Hospital service provider <b>contact number</b>		
Hospital service provider <b>web site address</b>		

<b>Section 2. New hospital name</b>					<b>Date change will take effect</b>
Hospital <b>name</b>					dd/mm/yyyy
<b>Section 3. New hospital address</b>					<b>Date change will take effect</b>
Hospital <b>address</b>					dd/mm/yyyy
<b>Section 4. New hospital contact number</b>					<b>Date change will take effect</b>
Hospital <b>telephone number</b>					dd/mm/yyyy
<b>Section 5. New hospital information</b>					<b>Date change will take effect</b>
Hospital <b>information</b>					dd/mm/yyyy
Hospital <b>type</b> e.g HSE public hospital or Voluntary public hospital	Hospital <b>setting</b> <b>type</b> e.g acute or community	Hospital <b>model</b> <b>type</b> e.g model 1,2,3 4, specialist or rehabilitation or community	Hospital <b>funding</b> <b>classification</b> e.g HSE funded, Section 38 Health Act 2004, Section 39 Health Act 2004	Name of <b>Regional Health Area/ Hospital Group/ CHO area where relevant</b>	

Section 6. Designated manager details					Date change will take effect
Designated manager		Designated manager Job title	Designated manager Email address	Designated manager Contact number	dd/mm/yyyy
First name	Last name				

Section 7. Declaration	
I, the undersigned, declare as the hospital service provider/on behalf of the hospital service provider that the information I have provided in this notification form is true to the best of my knowledge and belief.	
Signed by (tick as appropriate)	Member of the committee of management or other controlling authority of an unincorporated body
	Member of the board, directorate or other governance structure of the body corporate
Name	
Job title	
Signature	
	<b>Type</b> your name in the signature field
Date	

Please email completed form to: [qualityandsafety@hiqa.ie](mailto:qualityandsafety@hiqa.ie)