Case # _____Participant Name:_____

NOTIFICATION OF ADDRESS/EMPLOYER CHANGE(S)

It is your responsibility to keep IPN informed of your current address and phone number and any change in employer status. Notify and obtain approval from IPN prior to starting employment or making any changes in any healthcare related position. If you fail to provide IPN with pertinent changes, or IPN is not able to communicate with you, your status with IPN is jeopardized and may result in contract termination from the IPN and a report to the Florida Board of Nursing. Please complete applicable portion of the form below.

Please duplicate this form prior to use

Change of Home Address

(changes can be made to your address through your Affinity eHealth Account)

Effective:_____ New phone: _____Circle one: Cell/Home
New Address: _____
City_____ State___ Zip _____ County_____

Change of Employment/Supervisor

Effective (date of hire): _____
Facility: _____
Mailing Address: _____
City _____State____ Zip _____ County_____
Street Address: _____
City _____State____ Zip _____ County_____
Contact person:_____#_____
Immediate Supervisor:_____ Credentials:_____
Supervisor Title:_____#_____
Supervisor e-mail:_____
My position:_____ Unit:_____ Shift:_____
My supervisor was informed of my IPN participation on:_____
to reach you at work:_____
My last day at previous employment:_____

Please return this form by fax 904-270-1633 OR Mail to:
IPN, P.O. Box 49130, Jacksonville Beach, FL 32240-9130