Radiation Oncology Practice Accreditation Program
1892 Preston White Drive
Reston, VA 20191

OWNERSHIP CHANGE/FACILITY ID DESIGNATION FORM

Please fill in ALL applicable accredited facility ID numbers for your location. **FML#**

All the information below must be completed.

Contact Name: **Title:**

Email Address: **Phone Number:**

Accredited Facility Name:

Facility Location Address:

1. **Is the facility under new ownership?** ☐ Yes ☐ No
   If so, the Effective Date of ownership change: _____
2. **Is the facility changing its name?** ☐ Yes ☐ No
   If so, New Name: _____
3. **Are any accredited facilities moving to a new location address?** ☐ Yes ☐ No
4. **Are the NPI, Medicare ID, EIN/Tax ID numbers, or both changing?** ☐ Yes ☐ No
5. **Were you required to complete a new CMS-855B form?** ☐ Yes ☐ No
6. **Are at least 50% of the radiation oncologists new?** ☐ Yes ☐ No
7. **Are at least 50% of the therapists new?** ☐ Yes ☐ No
8. **Are there significant changes in the treatment protocols?** ☐ Yes ☐ No
9. **Is the Medical Director changing?** ☐ Yes ☐ No

Former owner information: _____
New owner information: _____

Name and Signature of Facility Medical Director, or Facility Administrator or Facility Owner (Old or New)

Name: **Title:**

Signature:

For ACR Use Only

Program Manager(s): _____ New ID # needed? ☐ YES ☐ NO