DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
OFFICE OF STATEWIDE HOSPITAL PLANNING AND DEVELOPMENT

Non-Material Alteration (NMA) Change Form

NMA Number:	Facility ID Number:	Client Document Name:	Issue Date:

Facility Name and Address:	HCAI/OSHPD Project Name and Number:

Subject of NMA Change:	☐ Contractor RFI ☐ Field Condition ☐ Owner Request ☐ DPOR Revision ☐ OIL Resolution	Attached Drawings/Sketches:

Description of NMA Change: If NMA is clearing outstanding item(s), provide details.

AOR/EOR Stamp and Signature: *Only required if not attaching drawings/sketches.*	HCAI/OSHPD Concurrence and Date:

Design Professional of Record

By my signature below, I acknowledge that the documents for the submittal type above have been reviewed and have been found to be in conformance with CAC Section 7-153(b) and the design of the project.

Signature of Architect or Engineer in Responsible Charge	Date: