CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

Change of Information Form

Social Security Number _____-_____-_____

_____ _____
First Name **Last Name**

(_____) _____-_____ x _____
Telephone Number

Position Title(s)/Option(s) for which request is being made:

_____

_____

_____

Information requested to be changed:

Current:
New:

_____ _____
Signature **Date**

Please return signed Change of Information Form to:

Central Management Services
Examining & Counseling Division
401 S. Spring Street
500 Stratton Office Building
Springfield, IL 62706