STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH CARE SERVICES
RESIDENTIAL LICENSING
PLAN OF CORRECTION

Name of Home: _____

Administrator: _____

This Plan of Correction is submitted in response to the Report of ☐ Inspection ☐ Investigation and Notice of Violation dated _____

This Plan of Correction is due _____

Violation	**Section I:** How will you correct this violation?	**Section II:** What measures will be taken to prevent future occurrences of this violation?	**Section III** How will these corrections be monitored?	**Section IV** By what **date** will this correction be completed?	**Section V** Is this correction complete?

(Print Addition pages if necessary)

I certify that the contents of this Plan of Correction and information provided with it are true, accurate, and complete.

I also understand that I will need to submit proof of each correction once they have been completed.

Printed Name of Person Completing Report	Title
Signature of Person Completing Report	Date

SECTION FOR DEPARTMENT USE ONLY

Yes	No	
☐	☐	Plan of Correction Accepted?

Date	Community Care Licensing Specialist I

Yes	No	
☐	☐	Corrections Completed?

Date	Community Care Licensing Specialist I