PERSONAL INFORMATION CHANGE FORM

Please mail or fax to:
State of Alaska Department of Health and Social Services
Background Check Program
4501 Business Park Blvd, Building L
Anchorage, AK 99503
Fax: (907) 269-3488
Intra-State Toll-free Fax: (888) 364-3488

Agency Name _____ **Agency ID** _____

Ind, Name _____ **Case ID/SSN** _____

1. Name and /or other Changes

Old Name: _____ New Name: _____

Other Changes: _____

2. Contact Information

Previous	**Update**
Mailing: _____	Mailing: _____
Physical: _____	Physical: _____
City:_____ State:_____ Zip Code:_____	City:_____ State:_____ Zip Code:_____
Email: _____	Email: _____
Phone Number: _____	Phone Number: _____

3. To Add/Delete Program and/or Position Title

If individual is going to work in an additional program and/or position **and** continue to work in the original program and position title originally cleared for, use just the add box. If individual is going to work in different program and/or position title and **is not** continuing to work in the original program and position title originally cleared for, use the delete box to delete original information and use the add box to add the new program and/or position title.

☐ Add ☐ Delete	☐ Add ☐ Delete
Program:_____	Program: _____
Position Title:_____	Position Title:_____

Revised 2/24/2012