State of Alaska
Dept. of Health and Social Services, Division of Health Care Services
Variance Transfer/Expiration Update Request

Return completed form to BCPVariance@alaska.gov

Applicant Name: Date of Birth:

Provider Name: Background Check Number:

Request for:

☐ Transfer of variance approval to new provider

☐ Extension of expiration date

The applicant's duties:

☐ Have not changed since the initial variance request.

The applicant continues in the position of:

☐ The applicant's duties may be similar to those of their previous employment.

The duties will be in the position of:

And include:

Name of Requestor (may be applicant or provider)

For Division Purposes only below this line

Applicant's barrier determination details:
Reason barred:
Dates of overall Ineligibility:

Applicant's original Variance Number:

Date of most recent background check:

☐ Verified no new criminal and/or civil history has been identified since last determination.

☐ Applicant's position has not changed and is maintaining employment for which the variance approval was granted, or

☐ Applicant's new position appears substantially similar to that for which the variance approval was granted.

Variance Chair