



Health Facilities Licensing & Certification
Inspection Waiver Application

Facility name: _____

CCN and/or AK License number: _____

Satellite locations: Yes No *(**If yes, inspection reports for these sites are also required)*

Physical address: _____

Mailing Address: _____

Primary phone: _____ Primary fax: _____

General email: _____

Administrator: _____ Administrator phone: _____

Administrator email: _____

Was this Administrator appointed in the past 12 months? Yes No

Secondary contact: _____ Contact phone: _____

Name of accrediting organization: _____

Date of last inspection: _____

Were any deficiencies identified during the last inspection? Yes No

If yes, have the deficiencies been corrected? Yes No

*****A copy of your last inspection report and plan of correction MUST be submitted with this application or the waiver will be denied.**

Application can be submitted by fax to 907-334-2682 or by email to dhcs.hflc@alaska.gov

FOR DIVISION USE ONLY

Date Application Received: _____ Includes requested attachments? Yes No

Application Reviewed by: _____ Date reviewed: _____

Application is: Approved Denied Approving Signature: _____