The State of Alaska
Department of Health and Social Services
Division of Health Care Services
Background Check Program

Variance Transfer/Extension Request

Return completed form to BCPVariance@alaska.gov

Applicant's Name:

BGC Number:

Name of Provider:

Oversight Agency:

Date request received by OSD:

Date submitted to variance committee:

OSD Recommendation

Extension Request:

☐ Yes, OSD recommends approval for this extension, including any prior conditions, if applicable.

☐ No, OSD does not recommend approval of this extension, due to the following reasons:

Transfer Request:

☐ Yes, OSD recommends the approval of this transfer, including any prior conditions, if applicable.

☐ No, OSD does not recommend approval for this transfer, due to the following reasons:

Name of OSD Representative completing the form: Date:

Save As **Click HERE to Submit by Email** **Clear Form**

FOR INTERNAL USE ONLY

Variance Committee Chair recommendations:

Barrier crimes/conditions for which Not Eligible was issued:

Longest barrier time frame, if more than one barrier is identified: to

Applicant's original variance approval date:

Date of last fingerprint check:

☐ VC verified no new criminal and/or civil history has been identified

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

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

Variance Chair/Co-Chair Signature: _____ Date: _____