State of Alaska
Department of Health
Application for General Variance

7 ACC 10.9510

State Licensing #: _____ License Expiration Date: _____ CCN #: _____

I. NAME AND LOCATION OF LICENSED ENTITY

Exact Legal Name: _____

Mailing Address: _____

Mailing City: _____ State: _____ Zip: _____

Physical Location (if different then mailing): _____

Physical City: _____ State: _____ Zip: _____

Main Phone Number: _____

Main Fax Number: _____

Fiscal Period (month/day) Start: _____ End: _____

II. ADMINISTRATION

Administrator's Name: _____

Address: _____

Phone Number: _____

Email Address: _____

III. INDIVIDUAL COMPLETING THIS FORM

Name: _____

Title: _____

Address: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

IV. REQUIREMENT

Please list the requirement(s) and regulatory references for which the variance is requested:

V. REASON FOR REQUEST

Please explain the reason for the variance request:

VI. COMPLIANCE

If the facility is unable to comply with the requirement(s), please provide a description of why the facility is not in compliance:

VII. COMPLIANCE CONT.

Please list the reason(s) why compliance with the requirement will impose a substantial economic, technological, programmatic, legal, or medical hardship on the facility and/or recipients of services:

VIII. PROPOSED ALTERNATIVE

Please describe the proposed alternative means of satisfying the purpose of the requirement(s) for which the variance is sought:

IX. HEALTH, SAFETY, AND WELFARE

Please descript how the health, safety, and welfare of the recipients of services will be protected during the period of variance.

X. PLAN FOR ACHIEVING COMPLIANCE

Please describe your plan for achieving compliance before the variance expires:

XI. FIRE SAFETY OR OTHER STATE OR MUNICIPAL REQUIREMENTS

If the variance involves fire safety or municipal requirements, please provide evidence that the request has been reviewed by the appropriate authority:

XII. VARIANCE TIME PERIOD

Please describe the period of time for which the variance is requested:

XIII. ADDITIONAL INFORMATION

The Department may request additional information to help it determine the effect of a variance on the health, safety, and welfare of the recipients of services. **If such information has been requested, please include it with your application.**

XIV. GOVERNING BODY (if applicable)

Has the Governing Body been advised of the compliance issues and variance alternative?* ◯ Yes ◯ No

Has the Governing Body approved the variance request?* ◯ Yes ◯ No

**Please attach any supportive documents from the facility's Governing Body.*

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XV. ATTESTATION

I the undersign am providing assurance that the conditions at the facility do not present an imminent danger to the health, safety, or welfare of recipients of services.

I certify that this information is true, complete, and contains no willful misrepresentation or falsification to the best of my knowledge and belief, and I understand that the terms of the original approved application and variance(s), if any, remain in effect unless changed by this variance.

I understand that Health Facilities Licensing & Certification staff may inspect a facility at any time to determine compliance with AS 47.32, 7 AAC 10, and 7 AAC 12 and I must permit representatives of the licensing agency to inspect my facility.

_____
Administrator or Designee (please print)

_____ _____
Signature of Administrator or Designee Date

**Please save a copy of this application for your own records.*

FOR OFFICIAL USE ONLY

Date request was received by the Department of Health: _____

Recommendations/Comments:

Department Reviewer: _____

Reviewer's signature: _____

Variance request decision: Select One

Decision date: _____ Waiver expiration date: _____