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

Variance TRANSFER Request

Applicant's Name:

Background Check # or Application #:

Provider Name:

Instructions: Please provide the requested information and submit this form to BCPVariance@alaska.gov.

Transfer request:

Current variance expiration date, if known:

Current Barrier expiration date as identified on Barrier Determination Notice:

Has there been any new negative criminal and/or civil history that has not been provided to the Background Check Program since the date of the last submitted fingerprints?

☐ Yes ☐ No If Yes, please explain:

Describe what the applicant's job duties and responsibilities will be:

Discuss with the applicant what their duties and responsibilities are/were for their current and/or previous employment for which the variance was issued. Use the space below to explain why you believe the position with your entity is similar, and within the same job class, as that for which the original variance was granted.

Briefly explain what type of supervision will be provided to the applicant.

Applicant Signature: _____ Date:_____

Provider Signature: _____ Date:_____

Provider Printed Name: _____ Provider Title:_____