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

Variance EXTENSION Request

Applicant's Name:

Background Check # or Application #:

Provider Name:

Instructions: Please provide the requested information and submit this form to BCPVariance@alaska.gov. This form MUST be submitted no later than 30 days prior to the expiration of the current variance approval.

Current variance expiration date:

Current Barrier expiration date as identified on Barrier Determination Notice:

Current conditions listed on variance approval, if any:

Applicant's position at the time of the original variance request:

Applicant's position at the time of variance extension request:

Has the provider and applicant complied with all conditions, if any, as listed on the variance approval?

☐ Yes ☐ No If No, please explain:

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:

Applicant Signature: _____ Date:_____

Provider Signature: _____ Date:_____

Provider Printed Name: _____ Provider Title:_____