



Request for Variance

Date Paid: _____
Receipt No.: _____

Official request to Fairfield County Combined General Health District Board of Health for variance from requirement(s) set forth in the Ohio Administrative Code.

Variance request fee = \$25.00

Please complete the following information:

Person Requesting Variance: _____

Address of Requestor: _____

Telephone Number: _____ Email Address: _____

Rule Variance Requested: _____

Please describe the reason for your variance request:

You must demonstrate that the rules are causing hardship to be considered for a variance from the OAC requirements.

PLEASE NOTE THAT VARIANCE FEE DOES NOT GUARANTEE THE VARIANCE REQUEST WILL BE APPROVED. VARIANCE REQUEST FEE IS NON-REFUNDABLE.

Signature of Requestor

Date

FOR OFFICE USE ONLY:

Sanitarian: _____

ERC Meeting Date: _____

Board Hearing Date: _____

ERC Recommendation: Approve Deny

Board Decision: Approve Deny

Resolution Number: _____

Additional Comments/Requirements: _____

