Date Paid: ___________
Receipt No.: _________

Request for Variance

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

Variance request fee = $110.00

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:

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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: ______________________________

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