Fairfield County Health Department

Request for Variance

Date Paid: _____

Receipt No.: _____

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 = $132.00

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: _____

_____

_____

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