Ashtabula County Health Department
12 West Jefferson St.
Jefferson, Ohio 44047
440-576-6010 Option 3

Variance Request #_____
Receipt Number _____
Fee Paid _____
Date Paid _____

VARIANCE REQUEST FORM

Note: 1. All variance requests must be submitted in complete form seven (7) days prior to the Ashtabula County Board of Health meeting. The cost is $ 75.00.

2. Variance approval must be executed within two (2) years of the date that a variance is granted. Variance approvals not executed within two (2) years of the date that the variance was granted become null and void.

Name of Requestor:_____

Mailing Address of Requestor:_____

Telephone Number of Requestor:_____

Name of Property Owner Requesting Variance:_____

Type of Variance Request:_____

Describe Nature of Variance Request:_____

_____

_____

Location of Variance Request (street address and directions to property):_____

_____

Has applicant provided a sketch of property depicting variance request?

_____ Yes _____ No

Has applicant provided a letter to Ashtabula County Health Department which states rationale for variance request?

_____ Yes _____ No

****

OFFICE USE ONLY

_____ _____

Sanitarians Signature **Date of Variance Request**

Board of Health Decision:

_____ _____ _____

Approved with conditions **Approved** **Disapproved**

_____

Health Commissioners Signature

Revised 2/14/2018