



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: _____

Identify Specific Rule(s) involved in 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