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

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OFFICE USE ONLY

_____ _____

Registered Environmental Health Specialist Signature **Date of Variance Request**

Board of Health Decision:

_____ _____ _____

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

_____

Health Commissioners Signature

Revised 10/19/2023