



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

 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