Champions of a safe and healthy community
Logan County Health District
310 S. Main St. Bellefontaine, OH 43311
PH:937-592-9040 Fax:937-592-6746
www.loganhealth.org

Office Use Only
Fee: $50 Date Paid:_____
Received by: _____
Receipt #: _____
Variance Request #: _____

VARIANCE REQUEST FORM

This is an official request to the Logan County Board of Health for a variance of the Ohio Administrative Code and/or a local health district regulation. All variance requests must be received in complete form at least seven (7) days before the Board of Health meets or action may be delayed until the next meeting. Variances not executed within two (2) years of the date granted become null and void.

Variance Location (please print) _____

_____ Township _____

Property Owner's Name _____ Phone _____

Property Owner's Address _____

Email _____ Installer/Contractor _____

Applicable Code/Rule For ☐ Well ☐ Sewage Variance _____

Variance Request Details
Provide diagrams or an explanation below showing how the variance meets the following conditions:

- No substantial health hazard or nuisance is likely to occur.
- Because of practical difficulties or special conditions, strict compliance with the code, rule and/or regulation would result in "unusual and unnecessary" hardship for the petitioner.
- No other technically feasible and economically reasonable means of compliance exists.
- No state, local or other applicable laws will be violated.
- The protection of the health, safety and general welfare of the public is assured.

_____

_____

_____ (Use other side or attach additional paperwork if needed.)

I, (print name) _____, as ☐ owner ☐ agent for the owner, of the property understand that the installation as stated on this request will not be in total compliance with the applicable rules. Should the system malfunction, I release all concerned provided they have conducted their duties in a reasonable and proper manner. I will promptly notify the Logan County Health District in the event of any system failure and make any corrections required by law. By signing the variance request form, I give permission for Logan County Health District representatives to enter onto the property to conduct such duties as may be necessary to evaluate the variance request.

Signature _____ Date _____

Continued from front page … _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

****

Office Use Only

Sanitarian's Recommendation _____

_____

_____

Signature _____ Date _____

Board of Health Action ☐ Approved ☐ Tabled ☐ Denied Date _____

Conditions/Restrictions/Comments _____

This Variance is Valid for Only Two (2) Years and Expires on Date _____

Health Commissioner Signature _____ Date _____

Applicant Notified By _____ Date _____

Method of Contact ☐ Phone Call ☐ Email ☐ Letter ☐ Other _____