Toledo-Lucas County Health Department
635 N Erie Street
Toledo, Ohio 43604
Phone: 419-213-4100 ext. 4
Fax: 419-213-4141
Website: www.lucascountyhealth.com

VARIANCE REQUEST APPLICATION FOR A SEWAGE TREATMENT SYSTEM

PROPERTY INFORMATION

Owner/Applicant		Township (of property)
Mailing Address	City	Zip Code
Email	Phone #	
Property Address	Zip Code	
Parcel Number, if known	Water Supply (city, well, other)	
Variance Request Fee: $75.00	Number of Bedrooms:	Basement: Yes No

Variance Request Information

******Please refer to the back of this application for Variance Request procedures and requirements******

Please use the space below to describe the reasons for the Variance Request. Additional pages can be attached as needed.

REHS recommendation to the Board: Approval Disapproval

REHS signature: _____

ADDITIONAL INFORMATON

1) Complete the Variance Application form.

2) Submit all supporting evidence and documentation supporting the request for variance.

3) Pay the required Variance application fee

Ohio law grants authority to the Board of Health to review and grant variances as follows:

The board of health may grant a variance from the requirements of 3701-29 of the Ohio Administrative Code when a person has made written application for a variance to the board requesting the variance from a specified rule or rules and the applicant shows that because of practical difficulties, or other special conditions, compliance with this chapter will cause unusual and unnecessary hardship. The board of health shall not grant a variance that would defeat the spirit and general intent of this chapter or is otherwise contrary to the public interest, adversely affect the public health, cause contamination of the environment, or not comply with the requirements of Chapter 3718. of the Revised Code.

This application will not be processed unless accompanied by the required fee(s).

** Make Checks Payable to the Toledo-Lucas County Health Department or TLCHD**

By signing below I acknowledge that I have read and agree to all terms and conditions on this application and that to the best of my knowledge all the information provided with this application is factual.	
Owner/ Applicant Signature:	Date:

----------Health Department Use Only----------

Received by:	Date:
Total Fee	**Receipt #**

Please indicate the section(s) of OAC 3701-29 the Variance Request is for:

_____

_____