INDIANA DEPARTMENT OF HEALTH DIVISION OF WEIGHTS AND MEASURES VARIANCE REQUEST FORM

Facility Name:	
County: Serial Number	of Device:
Physical Address of Device:	
City: Zip Code:	
Phone: Email:	
Attach the following to this form:	
1) The specific variance request you are making.	
2) Reason/justification for requesting variance.	
3) Scaled drawing showing proposed physical changes.	
4) Any additional relevant information.	
Should the variance be approved, Indiana Weights & Measures may impose an expiration date for the variance and other conditions to ensure the accuracy of the device. Other conditions may include but will not be limited to alternative construction, maintenance requirements, and reduced testing intervals (e.g. two times annually).	
X	X
X Applicant Name (Print)	X Owner Signature
X	
Applicant Signature	Date
× □	FOR OFFICE USE ONLY
Special Conditions Imposed:	
Variance Expiration No Yes Date Expires	
Approved Not Approved	Approved Not Approved
Inspector Re	view Director Review