



NOBLE COUNTY HEALTH DEPARTMENT

2090 N. State Road 9, Suite C
Albion, Indiana 46701

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Clinic Fax: (260) 636-3753

Variance/Appeal Application

Request for variance from the Ordinance 31998-16, Section 16-1-3-13

Name of Applicant: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Premises Affected:

Address: _____

City: _____ State: _____ Zip: _____

Lot: _____ Subdivision: _____ Township: _____ Section: _____

Parcel Number: _____ Acres / Square Feet: _____

Detailed description of the variance applied for and full statement of reasons for variance or reasons for appeal: _____

NOTE: Needed is a detailed layout of the area involved showing locations of well and septic systems involved, lot measurements, roads, lakes, any topographical circumstances that will affect any development.

THE ABOVE INFORMATION, TO MY KNOWLEDGE & BELIEF, IS TRUE & CORRECT.

Date: _____ Signature: _____

This is to verify \$50.00 was received this day _____ of _____, 20_____.

For a variance/appeal application fee, by _____ Rec. Number: _____

Date & Place of public hearing _____ 6:30 P.M., South Office Complex, Albion.

APPEAL OR VARIANCE: _____ Granted: _____ Denied: _____

If Granted, Subjected to following conditions: _____

If Denied, reasons: _____

Health Officer

Board Chairman