

## Variance Request Form

For variance requests related to the food and lodging codes adopted by City Ordinances 440 & 441 Government data practices act-Tennesson warning: The data you supply on this form will be used to process the license you are applying for. You are not legally required to provide this data, but we will not be able to process the license without it. The data will constitute a public record if and when the license is granted.

<b>Name of Establishment:</b> _____				
Physical Address: _____				
	Street	City	State	Zip
Mailing address: _____				
	Street	City	State	Zip
Phone: _____ Fax: _____ License#: _____				
<b>Owner Name:</b> _____				
Physical Address: _____				
	Street	City	State	Zip
Mailing address: _____				
	Street	City	State	Zip
Phone: _____ Fax: _____ Email: _____				
<p>Note: Variances cannot be granted for any of the following provisions of the Minnesota Food Code: 4626.0020, subpart 35; 4626.0040 to 4626.0060; 4626.0065 to 4626.0100; 4626.0105 to 4626.0120; 4626.1565; 4626.1590; 4626.1595; and 4626.1600 to 1626.1675</p> <p>Length of time for which the variance is requested for: _____</p> <p>Have you applied or received a variance from MDA, MDH or another MN jurisdiction for the identical product of process you are applying for now?      No      Yes      (If yes, attach a copy of approval or denial)</p>				
<b>Office use only</b>				
<b>Date Application was Received:</b> _____		<b>TRAKIT Code:</b> _____		
<b>Was the application complete:</b> _____		<b>Approved</b>	<b>Denied</b>	
<b>Remark or basis for approval or denial:</b> _____				
_____				
<b>Health Director signature:</b> _____			<b>Date:</b> _____	

**Variance Request Form page 2 of 2**

Please answer the following. Attach additional pages if needed.

Cite the rules for which the variance is requested:

---

---

---

State the reason why the rule cannot be met :

---

---

---

Describe what the proposed variance will allow the establishment to do :

---

---

---

Explain alternative measures that will be taken to ensure equivalent protection:

---

---

---

Submit completed application to:

Health & Inspections Department  
City of St. Cloud  
400 2<sup>nd</sup> St. South  
St. Cloud MN 56301

I certify that I am authorized to represent the licensee (owner, partner, corporate officer, etc.) and that I have personally examined and am familiar with the information submitted in this and all attached documents. I believe that all information submitted in this application is true, accurate, and complete.

I understand that there are penalties for submitting incorrect information and that any variances granted based on false information will be made null and void.

I agree to comply with the terms of the variance, if granted, and, if needed, will provide other relevant information the regulatory authority determines necessary to properly evaluate the request for the variance.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed name** \_\_\_\_\_