APPLICATION OF APPEAL

ST. CLAIR COUNTY HEALTH DEPARTMENT
BOARD OF APPEALS

3415 – 28th STREET, PORT HURON, MI 48060
Phone: (810) 987-5306 / Fax: (810) 985-5533
environmentalhealth@stclaircounty.org

NAME OF APPELLANT _____ PHONE: ( ) _____

MAILING ADDRESS _____
(Address and Street) (City/State) (Zip)

ADDRESS/APPEAL PROPERTY _____ DATE OF DENIAL _____
(Road) (Township)

REASON FOR DENIAL _____

EXPLAIN WHY YOU SEEK VARIANCE FROM THE ABOVE REQUIREMENTS OF THE ST. CLAIR COUNTY E.H. CODE:

_____

_____

_____

DOES THE PERMIT DENIAL BY THE HEALTH DEPARTMENT RESULT IN A HARDSHIP TO YOU? ( ) YES ( ) NO

If yes, please provide a brief summary of how, and attach any supporting documentation, date or other information, which will support your claim of hardship: (Use additional paper if needed)_____

_____

_____

_____

Are you the owner of record for this property? _____ If no, are you attempting to purchase? _____

Do you intend to live on this property? _____ If no, do you intend it to be for investment? _____

Will any other variances or special permits be required from other units of government in order to develop this property? _____ If yes, please explain: _____

_____

*MAKE CHECK FOR APPEAL FEE OF $350.00 PAYABLE TO: **SCCHD**

I hereby affirm that the information contained as part of this application of appeal is true and accurate to the best of my knowledge and belief.

_____

(Signature of Appellant) *(Date)*