



# APPLICATION OF APPEAL



## ST. CLAIR COUNTY HEALTH DEPARTMENT BOARD OF APPEALS

3415 – 28<sup>th</sup> 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 St. Clair County Health Dept.**

*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)