

APPLICATION FOR FOOD ESTABLISHMENT VARIANCE

(Please type or print in blue or black ink)

ESTABLISHMENT NAME (dba):	
ESTABLISHMENT LOCATION ADDRESS:	
STREET: _____	
CITY: _____	ZIP CODE: _____
OWNER NAME (Corp., LLC, Partnership, Sole Owner, Other):	
CONTACT PERSON:	CONTACT PHONE NO.:
I understand that approval of the submitted food establishment variance is contingent upon compliance with the requirements of Hawaii Administrative Rules, Title 11, Chapter 50, section 13 "Variances," and after approval, the variance may be revoked at any time if the variance becomes a threat to public health and safety, and for failure to comply with the provisions of this section.	
DATE _____	SIGNATURE OF OWNER/AGENT WITH AUTHORITY _____
PHONE # OF OWNER/AGENT WITH AUTHORITY _____	PRINT NAME _____ TITLE _____
OWNER/AGENT MAILING ADDRESS:	
STREET: _____	
CITY: _____	STATE: _____ ZIP CODE: _____

(OFFICIAL USE ONLY) FEE AMOUNT:	\$200
(NON REFUNDABLE)	

Payable to: STATE OF HAWAII
Submit application and fee to: SANITATION BRANCH
 591 ALA MOANA BLVD.
 HONOLULU, HI 96813

THERE WILL BE A SERVICE FEE OF \$25.00 FOR ANY CHECK DISHONORED BY THE BANK.

TYPE OF VARIANCE REQUESTED (select one):

<input type="checkbox"/> Smoking food for preservation [§11-50-34(j)(1)]	<input type="checkbox"/> Reduced oxygen packaging [§11-50-34(j)(4)]
<input type="checkbox"/> Adding food additives for food preservation [§11-50-34(j)(3)]	<input type="checkbox"/> Sprouting seeds or beans [§11-50-34(j)(8)]
<input type="checkbox"/> Molluscan shellfish life-support tank [§11-50-34(j)(5)]	<input type="checkbox"/> Curing food [§11-50-34(j)(2)]
<input type="checkbox"/> Custom processing animals for personal use [§11-50-34(j)(6)]	
<input type="checkbox"/> Other – Process method determined to require a variance [§11-50-34(j)(7)]	
<input type="checkbox"/> Other – Rule modification or waiver request for items not involving specialized processes.	

I certify that I have knowledge of the facts herein set forth and that the same are true and correct to the best of my knowledge and belief.

Signature of owner/agent _____ Print name _____ Date _____

SECTION BELOW FOR OFFICIAL DEPARTMENT OF HEALTH USE ONLY

Fee Paid	Date Paid	Method of Payment	Receipt No.	Received By
RECEIVED BY: NAME: _____ DATE: _____ REFERRED TO: _____				
INSPECTOR APPROVAL: NAME _____ DATE: _____ SUPERVISOR APPROVAL: NAME: _____ DATE: _____				
DATE OF PUBLIC HEARING: _____ DOCKET NUMBER: _____				
APPROVED BY: _____ Date _____ Signature of Agent/Dept. of Health _____				