SANITATION BRANCH
99-945 HALAWA VALLEY STREET
AIEA, HAWAII 96701
TELEPHONE NUMBER: (808) 586-8000 FAX: (808) 586-8040

STATE OF HAWAII
DEPARTMENT OF HEALTH
www.health.hawaii.gov

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**
99-945 HALAWA VALLEY STREET
AIEA, HI 96701

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

TYPE OF VARIANCE REQUESTED (select one):

☐ Smoking food for preservation [§11-50-34(j)(1)]

☐ Adding food additives for food preservation [§11-50-34(j)(3)]

☐ Molluscan shellfish life-support tank [§11-50-34(j)(5)]

☐ Custom processing animals for personal use [§11-50-34(j)(6)]

☐ Other – Process method determined to require a variance [§11-50-34(j)(7)]

☐ Other – Rule modification or waiver request for items not involving specialized processes.

☐ Reduced oxygen packaging [§11-50-34(j)(4)]

☐ Sprouting seeds or beans [§11-50-34(j)(8)]

☐ Curing food [§11-50-34(j)(2)]

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

PERMIT NO.: _____ EXP DATE: _____