

INDIANA DEPARTMENT OF HEALTH
DIVISION OF WEIGHTS AND MEASURES
VARIANCE REQUEST FORM

Facility Name: _____

County: _____ Serial Number of Device: _____

Physical Address of Device: _____

City: _____ Zip Code: _____

Phone: _____ Email: _____

Attach the following to this form:

- 1) The specific variance request you are making.
- 2) Reason/justification for requesting variance.
- 3) Scaled drawing showing proposed physical changes.
- 4) Any additional relevant information.

Should the variance be approved, Indiana Weights & Measures may impose an expiration date for the variance and other conditions to ensure the accuracy of the device. Other conditions may include but will not be limited to alternative construction, maintenance requirements, and reduced testing intervals (e.g. two times annually).

X	X
Applicant Name (Print)	Owner Signature
X	Date
Applicant Signature	Date
Variance drawing attached <input type="checkbox"/>	BELOW FOR OFFICE USE ONLY

Special Conditions Imposed:

Variance Expiration No Yes Date Expires _____

<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved
Inspector Review	Director Review