



Wisconsin Department of Agriculture, Trade and Consumer Protection  
 Division of Food and Recreational Safety, PO Box 8911, Madison, WI 53708-8911  
 Phone: (608) 224-5036 Fax: (608) 224-4710

Wis. Stat. ch. 97

# VARIANCE APPLICATION

**Only the Licensed Individual or Married Couple or Legally Authorized Representative of the Licensed Legal Entity May Submit This Application, With Only a Single Variance Request Per Application:**

**REQUESTOR:**

LICENSEE NAME (Individual, Married Couple or Legal Entity):	LICENSEE NUMBER
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**AFFECTED ESTABLISHMENT INFORMATION (Please check one):**

<input type="checkbox"/> Restaurant/Retail Food Establishment	<input type="checkbox"/> Pool	<input type="checkbox"/> Hotel / Motel
<input type="checkbox"/> Temporary Restaurant	<input type="checkbox"/> Water Attraction	<input type="checkbox"/> Tourist Rooming House / Cabin / Cottage
<input type="checkbox"/> Mobile Restaurant or Retail Food Establishment	<input type="checkbox"/> Water Attraction with Slides	<input type="checkbox"/> Bed and Breakfast Establishment
<input type="checkbox"/> Caterer	<input type="checkbox"/> Campground	<input type="checkbox"/> Other:
<input type="checkbox"/> Special Organization Serving Meals	<input type="checkbox"/> Special Event Campground	
<input type="checkbox"/> Vending Machine Operation	<input type="checkbox"/> Recreational Educational Camp	

AFFECTED ESTABLISHMENT NAME	AFFECTED ESTABLISHMENT LICENSE NUMBER
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AFFECTED ESTABLISHMENT ADDRESS STREET	CITY	STATE	ZIP
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New    Existing    Change of Ownership

**VARIANCE REQUEST INFORMATION**

**1. Cite specific state administrative code reference being petitioned (i.e. 2009 Food Code 3-501.13 Thawing):**

**2. What specific practice, operation, condition, construction, equipment, installation or issue is the variance requested for? Explain in detail:**

**3. Explain in detail why compliance cannot be attained without a variance:**

4. How will the proposed variance meet the intent of the administrative code to provide the same means of protection of health, safety or welfare? Explain in detail:

Submit all pertinent and representative photographs, sketches, diagrams, relevant and current documentation, test reports, research articles, expert opinions, testing certifications, manufacturers' required standards conformance, or any other document the licensee believes is relevant to the decision. Failure to provide this information in a timely manner may result in denial of the variance request.

If you have received a previous variance approval, please include the written approval, signed by a DFRS or local agent health department official. If you do not have a written approval, submit the approving agency and approving official's name, title, telephone number, and e-mail address.

Upon receipt of a complete variance request, the Department shall review the request and grant or deny the request in writing within 30 working days. Incomplete applications may delay the process.

Please make a copy of this application and all attachments, as submitted documents are state records and will not be returned.

**Submit documents to Agent Health Department, or DATCP Field Sanitarian.**

I attest, by my signature, that I am the individual or married couple licensee or the legally authorized representative of the legal entity licensee and the information contained in this application and attachments accurately and truthfully represents the conditions and circumstances relevant to the request. I understand that I am prohibited from giving false information, pursuant to Wis. Stat. §§ 97.12(4) (b) and 97.65(5) (b) 2. I understand that the Division may grant any variance with any or all of the following: as experimental trial only, with conditions or an expiration date. Pursuant to Wis. Stat. § 15.04 (1) (m), personal information provided may be used for purposes other than that for which it was originally collected.

SIGNATURE OF LICENSEE OR AUTHORIZED REPRESENTATIVE FOR LICENSEE		PRINT NAME		DATE
REPRESENTATIVE STREET ADDRESS		CITY	STATE	ZIP
REPRESENTATIVE PHONE: ( ) -	REPRESENTATIVE CELL PHONE: ( ) -	REPRESENTATIVE FAX NUMBER: ( ) -	REPRESENTATIVE E-MAIL ADDRESS:	

AGENT HEALTH DEPARTMENT OR DATCP FIELD SANITARIAN USE ONLY	
NAME:	TITLE:
AGENCY:	DATE:
EMAIL ADDRESS:	PHONE: ( ) -
<input type="checkbox"/> Approve <input type="checkbox"/> Deny	COMMENTS:
OFFICIAL'S SIGNATURE:	PRINTED NAME:
<b>Agent or DATCP Sanitarian – please submit documents by e-mail to:</b> <a href="mailto:DATCPDFRSRetail@wi.gov">DATCPDFRSRetail@wi.gov</a> (for a food facility) <a href="mailto:DATCPDFRSRec@wi.gov">DATCPDFRSRec@wi.gov</a> (for a recreational facility)	Or mail to: WDATCP - DFRS Attn: Technical Section - Variance PO Box 8911 Madison, WI 53708-8911