

REQUEST FOR VARIANCE

AGENCY : Otter Tail County Human Services 530 W Fir Fergus Falls MN 56537

LICENSOR Linda Hanstad

PROVIDER NAME (print clearly) _____

ADDRESS _____ PHONE: (218) _____

CITY, STATE AND ZIP CODE _____

TYPE OF CARE : Family Child Care CLASS OF LICENSE: _____

1. FOR WHAT SECTION OF THE RULE DO YOU WANT A VARIANCE? _____

2. DESCRIBE HOW YOU WILL BE OUT OF COMPLIANCE _____

2. WHY ARE YOU REQUESTING THE VARIANCE? _____

3. FOR WHAT TIME PERIOD ARE YOU REQUESTING THE VARIANCE - BEGINNING AND ENDING DATES: (include days of week and hours of the day if appropriate)? _____

4. IF THE VARIANCE IS APPROVED, WHAT ADDITIONAL **SPECIFIC** ALTERNATIVE MEASURES WILL YOU PROVIDE FOR THE HEALTH, SAFETY AND PROTECTION OF THE CHILDREN IN YOUR CARE? _____

Provider Signature: _____ DATE _____

Approved by Licensor: _____ DATE _____