

CONSENT, ZONING, SUBDIVISION OR LAND USE EVALUATION

Environmental Health Services
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Northeastern
PUBLIC HEALTH
SANTÉ PUBLIQUE
du Nord-Est

Health Unit file number: _____ Date received: |YEAR |MONTH |DAY Receipt: _____
 Cash Debit MO Cheque Visa MC

The Health Unit requires 15 working days to complete this request. **An application from the Planning Authority/Board and diagram must be submitted with the fee schedule.** Subject to change without notification. Note: If the information requested is NOT COMPLETE or is INCORRECT, this application CANNOT be processed.

Please print clearly

Request from: _____

Mailing address: _____ City/Province: _____

Postal code: _____ Phone: _____ Fax: _____

Residential Commercial (Name and type of commercial property): _____

Legal description

Municipality: _____ Township: _____ Lot: _____ Conc.: _____

Parcel(s): _____ Plan No(s): _____ Sublot(s): _____

PIN: _____ Other: _____

House number: _____ Street/Road: _____ City: _____

Directions to property (show highways, roads, signs, landmarks, etc. to follow) Please note: Extraordinary travel costs by air, water, etc. are to be incurred by the applicant.

Fee schedule

1. Consent application(s)

2 (1 retained + 1 severed)	Lots @	\$300.00	=	\$600.00	
3 (1 retained + 2 severed)	Lots @	\$300.00	=	\$900.00	
4 (1 retained + 3 severed)	Lots @	\$300.00	=	\$1,200.00	
5 (1 retained + 4 severed)	Lots @	\$300.00	=	\$1,500.00	
Fee payable					\$

2. Zoning/Minor variance application(s)

1	Zoning@ \$250.00 (if not part of consent application)	Fee payable	\$
1	No cost for zoning if submitted with a consent application.		

3. Subdivision application(s) \$300.00 per lot up to a maximum of \$5,000.00 # of lots [] x \$300.00 = **Fee payable** **\$**

4. Land Use Evaluation # of lots [] x \$325.00 = **Fee payable** **\$**

Site plan diagram

See attached diagram/site plan

Indicate North

I hereby certify that the information contained in this application is correct to the best of my knowledge.

Signature: _____

Date: |YEAR |MONTH |DAY

Authorization

Authorization is required when this request is made by a person who is not the registered owner. I, the owner, hereby authorize Northeastern Public Health to release any information for the above-noted property in the possession of Northeastern Public Health to the said agent.

Name of authorized agent: _____

Agent mailing address: _____ City/Province: _____

Postal code: _____ Phone: _____ Fax: _____

Owner(s) name (print clearly): _____

Owner(s) signature required: _____

Date: |YEAR |MONTH |DAY

To meet public health requirements, any personal information on this form is collected under the authority of one or more of the following (as amended) and related regulations: *Health Protection and Promotion Act, R.S.O. 1990; Smoke-Free Ontario Act, S.O. 2017; Skin Cancer Prevention Act, S.O. 2013; Healthy Menu Choices Act, S.O. 2015; Safe Drinking Water Act, S.O. 2002; Ontario Building Code Act, S.O. 1992; Funeral, Burial and Cremation Services Act, S.O. 2002; Environmental Protection Act, R.S.O. 1990; Regulated Health Professions Act, S.O. 1991; and is in compliance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 and the Personal Health Information Protection Act, S.O. 2004.* Questions about this collection should be directed to the Program Manager at Northeastern Public Health, Timmins office, 1-877-442-1212 ext 4118.