**REQUEST FOR REFUND**

TO: **KY DEPARTMENT FOR PUBLIC HEALTH**

**DIVISION OF PUBLIC HEALTH PROTECTION AND SAFETY**

**275 E. Main Street HS1E-B**

**Frankfort, KY 40621**

FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINTED/TYPED NAME) (DATE)

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(SIGNATURE) (TITLE)

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(HEALTH DEPARTMENT)

**PLEASE REFUND THE FOLLOWING FEE**:

NAME & ADDRESS OF TYPE OF AMOUNT OF PERMIT #: APPLICANT: ESTABLISHMENT: REFUND:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_

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**REASON FOR REFUND**:

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LHD Appointing Approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**DPH Appointing Approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**