KITCHEN REQUIREMENTS

PLEASE CIRCLE REASON FOR APPLICATION:

New Facility **Change of owner** **Change of Facility** **Addition to Facility**

Date: _____ **Proposed # of Seats:** _____ **Proposed # of Staff:** _____

Project or Facility Name: _____

Address: _____

Person to Contact: _____

Phone #: _____ **Email:** _____

PLEASE MARK:

___ Floor plans of facility provided and drawn to scale. Scale must be shown on the floor plan.

___ Utility bill showing sewer charges or letter of sewer connection provided.
If facility is on septic, answer next line.

___ Facility is on septic. Must fill out Existing System Verification OR modify existing annual operating permit if applicable.

___ Water supply (public water or well)

___ Plan Review fee, Annual Permit fee and ABT sign-off fee paid

___ 1 toilet shown on floor plan for every 40 patrons and/or staff.

___ 1 hand wash sink shown on floor plan for every 75 patrons and/or staff in each restroom.

___ 1 mop sink shown on floor plan.

___ Three compartment sink shown on floor plan.

___ Hand wash sinks in service, prep and dishwashing areas.

___ Prep sink in food preparation area.

_____ _____
Signature of Owner or Owner's Representative Date

Revised 9/28/21

Florida Department of Health in Orange County

Plans Review Routing Sheet

Please note that the fee for plan review is $53.00, in addition to the permit application fee. Please sign below to acknowledge and certify that all of the information provided for permit approval is true and correct.

Facility Name: _____

Facility Address: _____

Mailing Address: _____

Type of Facility: _____ Number of Employees: _____

Number of Clients, Students, Customers or Seating Capacity: _____

Method of Sewage Disposal: _____Water Supply: _____

Person to Contact: _____ Phone #: _____

Signature: _____ **Date:** _____

For Office Use Only

Date: _____ Plan Review Routing Number: _____

Payment Type: _____ Amount Paid: $_____ Check Number: _____

Utility Reviewer: _____ **Date:** _____

Remarks: _____ **APPROVAL STAMP**

_____

_____

_____

SIGNATURE: _____

Program Reviewer: _____ **Date:** _____

Remarks: _____

_____

_____

_____ **SIGNATURE:** _____

STATE OF FLORIDA
DEPARTMENT OF HEALTH

Certificate Number

APPLICATION FOR SANITATION CERTIFICATE

AUTHORITY: Chapter 381.0072, Florida Statutes

Instructions: 1. Complete the information requested below. 2. Sign the application and return along with a completed set of plans drawn to scale and required fee (do not send cash), to the Environmental Health (EH) office of the County Health Department. A new application is not required for annual renewal unless the information below changes.

NAME OF FACILITY_____

LOCATION_____
Street City State ZIP Code

OWNER'S NAME_____ EMAIL ADDRESS_____

OWNER'S ADDRESS_____
Street City State ZIP Code

OWNER'S PHONE_____ BUSINESS PHONE_____

Type of Food Service Subtypes Select One:

	Adult Day Care		Afterschool Meal		Assisted Living Facility
	Bar/Lounge		Civic/Fraternal Organization		Crisis Stabilization Unit
	Detention Facility		Domestic Violence Shelter		Home for Special Services
	Hospice		Intermediate Care Facility		Migrant Labor Camp
	Movie Theater		Prescribed Pediatric Extended Care Center (PPEC)		Recreational Camp
	Residential Treatment Facility (AHCA)		School		Short Term Residential Treatment (DCF)
	Transitional Living Facility		Other:		

Food Service Operations Select One:

	Afterschool Meal		Bakery		Boarding School
	Canteen		Caterer		College/University Cafeteria
	Concession Stand		Culinary Education		Deli/Sandwich Shop
	Main Operation		Mobile Food Unit		Non-Alcoholic Beverage
	Restaurant		Retail Food Store		Satellite Kitchen
	School (9 months or less)		School (greater than 9 months)		Temporary Event Sponsor
	Temporary Event Vendor		Vending Machine (TCS/PHF)		Other:

Comment/Special Instructions: _____

FOR EH USE ONLY: Annual Fee for Your Facility: $_____.

Please make check or money order payable to: Florida Department of Health in _____ County.

The undersigned owner/owner's representative hereby agrees to operate the food establishment described in this application in accordance with the requirements of Chapter 381.0072, Florida Statutes, and Chapter 64E-11, Florida Administrative Code,. The information contained in this application, which serves as the basis for licensure, is true and correct. I understand that any misrepresentation to the facts in this application, or failure to comply with sanitary standards, is grounds for denial or revocation of the sanitation certificate.

_____ _____
Signature (Facility Owner/Owner's Representative) Date Signature (EH Official) Date

STATE OF FLORIDA
DEPARTMENT OF HEALTH

FOOD SERVICE ESTABLISHMENT PLAN REVIEW APPLICATION

Instructions: 1. Complete the information requested below. 2. Sign the application and return along with a set of scaled plans, for both new and remodeled establishments, showing all kitchen equipment with specifications, plumbing fixtures, bars, storage areas, etc. Also, submit the proposed menu listing specific foods. Submit all the above to the Environmental Health (EH) office of the County Health Department. Grease traps must meet all local plumbing codes and be located so they can be easily cleaned.

Plan Review Type: ☐ **New** ☐ **Remodel** **Property Appraiser Assessed Value (if remodel): $**_____

Printed Name of Property Appraiser: _____

Signature of Property Appraiser: _____ **Date:** _____

Name of Establishment: _____

Establishment Address: _____
Street City State ZIP Code

Owner/Owner's Representative Name & Title: _____

Owner/Owner's Representative Address: _____
Street City State ZIP Code

Phone Number: _____ Email: _____

Type of Food Service Establishment:

Bar/Lounge ☐ Concession Stand ☐ Detention Facility ☐ Mobile Food Unit ☐ Fraternal/Civic ☐

Movie Theater ☐ School ☐ Residential Type Facility (List Type) _____

(Full Service Operation: ☐ Limited Prep: ☐ Packaged Products Only: ☐)

Projected Start Date of Project: _____ Projected Completion Date of Project: _____

Is property on an onsite sewage system (septic tank)? ☐ Yes ☐ No (If yes, submit a completed evaluation of capacity.)

Is property served by an onsite/private well? ☐ Yes ☐ No (If yes, submit a completed evaluation of capacity.)

Plans have been submitted to (circle all that apply): Zoning Plumbing Planning Fire Authority Building

The undersigned owner/owner's representative hereby agrees to operate in accordance with the requirements of Chapter 381.0072, Florida Statutes, and Chapter 64E-11, Florida Administrative Code. The information contained in this application, which serves as the basis for licensure, is true and correct. I understand that any misrepresentation to the facts in this application, or failure to comply with sanitary standards, is grounds for denial or revocation of the sanitation certificate.

_____
Owner/Owner's Representative Name & Title

_____
Owner/Owner's Representative & Date