

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

Celeste Philip, MD, MPH
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

GROUP CARE FACILITY REQUIREMENTS

Reason for Application: new facility change of ownership change to facility (please circle)

This sheet must be completed for all new group care facilities. If this is a change of ownership, you must also complete this form but you will be held to the plumbing code at the original time of permitting until the facility is expanded or changes use.

DATE: _____ PROPOSED # OF RESIDENTS: _____ PROPOSED # OF STAFF: _____

PROJECT NAME: _____

ADDRESS: _____

PERSON TO CONTACT: _____ PHONE #: _____

_____ 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 paid

_____ Primary Licensing Agency (e.g. AHCA, DCF, APD, etc.)

_____ 1 toilet shown on floor plan for every 10 patrons.

_____ 1 shower or bathtub on floor plan for every 8 patrons.

_____ 1 hand wash sink shown on floor plan for every 10 patrons.

_____ 1 mop sink shown on floor plan.

_____ Number of beds / Number of bedrooms.

Y / N Is this facility providing 24-hour care, limited nursing care or mental health care?

Y / N Does this facility prepare or serve catered meals? If yes – provide intended menu, name of caterer

Group care facility kitchen sink requirement. Applicable kitchen sinks must be shown on floor plan.

_____ 5 or fewer residents, 1 sink required in kitchen.

_____ 6 – 10 residents, 1 compartment sink and a mechanical dishwasher capable of sanitization and 1 hand wash sink or a 2 compartment sink with a hand wash sink in the kitchen.

_____ 11 or more residents, 2 compartment sink and a mechanical dishwasher capable of sanitization and 1 hand wash sink or a 3 compartment sink with a hand wash sink in the kitchen.

Owner Signature & Date

Representative Signature & Date

Revised 03/16/16

Florida Department of Health in Orange County

Division of Environmental Health
1001 Executive Center Drive, Orlando, FL 32803
PHONE: 407/858-1497 • FAX 407/228-1403 or 1467
<http://orange.floridahealth.gov/>



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ORANGE COUNTY HEALTH DEPARTMENT PLANS REVIEW ROUTING SHEET

DATE: _____ PLANS ROUTING NUMBER: _____
PAYMENT TYPE: _____ AMOUNT: _____ CHECK NUMBER: _____

Please note, the fee for plan review is \$48 per hour. If your plan review requires additional time or requires revisions, you will be charged an additional \$48 per hour before approval. Please sign below to acknowledge your understanding and acceptance of these conditions. By signing below, you are also certifying that the information provided is true and correct.

SIGNATURE: _____ DATE: _____

FACILITY NAME: _____

FACILITY ADDRESS: _____

BILLING 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 #: _____

FOR OFFICE USE ONLY

UTILITY REVIEWER: _____ DATE: _____

REMARKS: _____ APPROVAL STAMP

SIGNATURE: _____

FACILITY REVIEWER: _____ DATE: _____

REMARKS: _____

SIGNATURE: _____

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APPLICATION FOR A SANITATION CERTIFICATE / PERMIT
Specific Authority: Chapter 381, FS

NAME OF FACILITY: _____

ADDRESS OF FACILITY: _____

BILLING ADDRESS: _____ ZIP CODE: _____

OWNERS NAME: _____

OWNER ADDRESS: _____

OWNER'S PHONE #: _____ BUSINESS PHONE # _____

TYPE OF FACILITY: _____ IS FOOD SERVED? _____

PLEASE FILL OUT A FACILITY DETAIL SHEET FOR ALL REQUIRED PERMITS AND CERTIFICATES

COMMENTS / SPECIAL INSTRUCTIONS: _____

The undersigned owner / owner's representative, hereby agrees to operate the permitted facility described in this application in accordance with the requirements of Chapter 381 FS and all applicable Florida Administrative Codes. 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 the sanitary standards of all applicable Florida Administrative Codes is grounds for denial or revocation of all permits and sanitation certificates.

SIGNATURE, OWNER / OWNER'S REPRESENTATIVE DATE

FOR OFFICE USE ONLY

INITIAL INSPECTION OF FACILITY: _____ APPROVED or DISAPPROVED: _____
DATE (circle one): DATE

SIGNATURE, INSPECTOR PRINT NAME, INSPECTOR

Revised 3/16/16