

Mission:

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



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

GROUP CARE FACILITY REQUIREMENTS

Reason for Application (please circle):

New Facility

Change of Ownership

Change to Facility

This sheet must be completed for all new residential 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: _____ ZIP CODE: _____

PERSON TO CONTACT: _____ PHONE: _____

EMAIL ADDRESS: _____

Waste Water

- Water bill showing waste water charges or letter of sewer connection provided OR
- 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 and Annual Permit fee paid
- Floor plans of facility provided and drawn to scale. Scale must be shown on the floor plan.
- 1 toilet shown on floor plan for every 10 patrons.
- 1 shower or bath tub 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
_____ Primary Licensing Agency (AHCA, DCF, APD, etc.)

Y / N Is this facility providing 24 hour care, limited nursing care or mental health care?
Y / N Does this facility prepare meals or serve catered meals? If yes - provide intended menu or name of caterer

Group care facility kitchen sink requirement. Applicable kitchen sinks must be shown on floor plan:
 5 or fewer residents, 1 sink and 1 hand wash sink required in kitchen.
 6 – 10 residents, 2 compartment sink and a hand wash sink in the kitchen OR a 1 compartment sink and a mechanical dishwasher capable of sanitization and 1 hand wash sink.
 11 or more residents, 3 compartment sink and a hand wash sink in the kitchen OR a 2 compartment sink and a mechanical dishwasher capable of sanitization and 1 hand wash sink.

Signature, Owner / Owner's Representative

Date

Rev 01222015

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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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STATE OF FLORIDA
DEPARTMENT OF HEALTH

Certificate Number

APPLICATION FOR A SANITATION CERTIFICATE

AUTHORITY: Chapter 381, Florida Statute

Instructions: 1. Provide the remainder of the information requested below. 2. If any of the pre-completed information is incorrect, please make necessary changes. 3. Sign the application and return it, along with the required fee (do not send cash), to the County Health Department. A new application is not required for next year's renewal as long as the information below remains the same.

NAME OF FACILITY _____

LOCATION _____
Street City State Zip Code

OWNER'S NAME _____

OWNER'S ADDRESS _____
Street City State Zip Code

OWNER'S PHONE _____ BUSINESS PHONE _____

Type of Food Service Establishment

<input type="checkbox"/>	School Cafeteria	<input type="checkbox"/>	Fraternal/Civic Lounge	<input type="checkbox"/>	Detention Facility
<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Bar/Lounge	<input type="checkbox"/>	Residential Facility
<input type="checkbox"/>	Nursing Home	<input type="checkbox"/>	Movie Theater	<input type="checkbox"/>	Other Food Service
<input type="checkbox"/>	Assisted Living Facility	<input type="checkbox"/>	Mobile Food Unit	<input type="checkbox"/>	Limited Food Service

COMMENTS/SPECIAL INSTRUCTIONS: _____

THE ANNUAL FEE FOR YOUR FACILITY is \$ _____ Please make check or money order payable to: _____ County Health Department

_____, _____, FL _____
Mailing address City Zip Code

Payment must be received at the above address before _____

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, 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, Owner/Owner's Representative

Date

Signature, Environmental Health

Date of Certificate

DH 4086, 7/98 (Replaces DH 4086, 12/97, Which may be used)
(Stock Number: 5744-000-4086-6)

Florida Department of Health in Orange County
Division of Division of Disease Control and Health Protection
Bureau of Environmental Health
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