

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



Ron DeSantis  
Governor

Scott A. Rivkees, MD  
State Surgeon General

Vision: To be the Healthiest State in the Nation

## **BARS AND CIVIC ORGANIZATION REQUIREMENTS**

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

This sheet must be completed for all new bars. 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 SEATS: \_\_\_\_\_ 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 and ABT sign-off fee paid

\_\_\_\_\_ 1 toilet shown on floor plan for every 40 patrons.

\_\_\_\_\_ Must show both men's and women's restrooms on floor plan.

\_\_\_\_\_ 1 hand wash sink shown on floor plan for every 75 patrons in each restroom.

\_\_\_\_\_ 1 water fountain shown on site plan for every 500 patrons.

\_\_\_\_\_ 1 mop sink shown on floor plan.

\_\_\_\_\_ Number of pool tables / video games.

\_\_\_\_\_ Three compartment sink in the bar area. Also needed in kitchen area for civic organizations.

\_\_\_\_\_ Hand wash sink in the bar area. Also needed in kitchen area for civic organizations.

Y/N Is this a civic organization that prepares food? Please keep in mind that food preparation is not permitted in bar facilities. Bars are permitted to serve prepackaged food and "bar" type food only.

\_\_\_\_\_  
Signature, Owner / Owner's Representative

\_\_\_\_\_  
Date

Revised: 08/11/16

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

Food Service Operations Select One:					
<input type="checkbox"/>	Afterschool Meal	<input type="checkbox"/>	Bakery	<input type="checkbox"/>	Boarding School
<input type="checkbox"/>	Canteen	<input type="checkbox"/>	Caterer	<input type="checkbox"/>	College/University Cafeteria
<input type="checkbox"/>	Concession Stand	<input type="checkbox"/>	Culinary Education	<input type="checkbox"/>	Deli/Sandwich Shop
<input type="checkbox"/>	Main Operation	<input type="checkbox"/>	Mobile Food Unit	<input type="checkbox"/>	Non-Alcoholic Beverage
<input type="checkbox"/>	Restaurant	<input type="checkbox"/>	Retail Food Store	<input type="checkbox"/>	Satellite Kitchen
<input type="checkbox"/>	School (9 months or less)	<input type="checkbox"/>	School (greater than 9 months)	<input type="checkbox"/>	Temporary Event Sponsor
<input type="checkbox"/>	Temporary Event Vendor	<input type="checkbox"/>	Vending Machine (TCS/PHF)	<input type="checkbox"/>	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 \_\_\_\_\_