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 08/11/16

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 $53 per hour. If your plan review requires additional time or requires revisions, you will be charged an additional $53 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: ________________________

Revised: 08/11/16

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