

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

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

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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 _____