

**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.

\_\_\_\_\_ **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:
  - o 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.
  - o 1 mop sink OR utility sink

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

\_\_\_\_\_  
Date

Rev 01222015

**Florida Department of Health in Orange County**

Division of Division of Disease Control and Health Protection  
 Bureau of Environmental Health  
 1001 Executive Center Drive Suite 200, Orlando, FL 32803  
 PHONE: 407 858 1497 • FAX 407 228 1467  
<http://orange.floridahealth.gov/>

**www.FloridasHealth.com**

TWITTER:HealthyFLA

FACEBOOK:FLDepartmentofHealth

YOUTUBE: fido

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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:** \_\_\_\_\_

**Florida Department of Health in Orange County**

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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

School Cafeteria	Fraternal/Civic Lounge	Detention Facility
Hospital	Bar/Lounge	Residential Facility
Nursing Home	Movie Theater	Other Food Service
Child Care Center	Assisted Living Facility	Mobile Food Unit
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