

Mission:

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



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the Healthiest State in the Nation

KITCHEN REQUIREMENTS

PLEASE CIRCLE REASON FOR APPLICATION:

New Facility **Change of owner** **Change of Facility** **Addition to Facility**

Date: _____ **Proposed # of Seats:** _____ **Proposed # of Staff:** _____

Project or Facility Name: _____

Address: _____

Person to Contact: _____

Phone #: _____ **Email:** _____

PLEASE MARK:

- 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 and/or staff.
- 1 hand wash sink shown on floor plan for every 75 patrons and/or staff in each restroom.
- 1 mop sink shown on floor plan.
- Three compartment sink shown on floor plan.
- Hand wash sinks in service, prep and dishwashing areas.
- Prep sink in food preparation area.

Signature of Owner or Owner's Representative
Revised 9/28/21

Date

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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 _____



FOOD SERVICE ESTABLISHMENT PLAN REVIEW APPLICATION

Instructions: 1. Complete the information requested below. 2. Sign the application and return along with a set of scaled plans, for both new and remodeled establishments, showing all kitchen equipment with specifications, plumbing fixtures, bars, storage areas, etc. Also, submit the proposed menu listing specific foods. Submit all the above to the Environmental Health (EH) office of the County Health Department. Grease traps must meet all local plumbing codes and be located so they can be easily cleaned.

Plan Review Type: New Remodel **Property Appraiser Assessed Value (if remodel):** \$ _____
Printed Name of Property Appraiser: _____
Signature of Property Appraiser: _____ **Date:** _____

Name of Establishment: _____
Establishment Address: _____
Street City State ZIP Code
Owner/Owner's Representative Name & Title: _____
Owner/Owner's Representative Address: _____
Street City State ZIP Code
Phone Number: _____ **Email:** _____

Type of Food Service Establishment:
Bar/Lounge Concession Stand Detention Facility Mobile Food Unit Fraternal/Civic
Movie Theater School Residential Type Facility (List Type) _____
(Full Service Operation: Limited Prep: Packaged Products Only:)

Projected Start Date of Project: _____ **Projected Completion Date of Project:** _____
Is property on an onsite sewage system (septic tank)? Yes No (If yes, submit a completed evaluation of capacity.)
Is property served by an onsite/private well? Yes No (If yes, submit a completed evaluation of capacity.)
Plans have been submitted to (circle all that apply): Zoning Plumbing Planning Fire Authority Building

The undersigned owner/owner's representative hereby agrees to operate 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.

Owner/Owner's Representative Name & Title

Owner/Owner's Representative & Date