Governor

Mission:

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



Joseph A. Ladapo, MD, PhD State Surgeon General

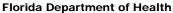
Vision: To be the Healthiest State in the Nation

SCHOOL REQUIREMENT SHEET

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

This sheet must be completed for all new schools. 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 CHILDREN:PROPOSED # OF STAFF:					
PROJECT NAME:						
ADDRES	S:ZIP CODE:					
PERSON	TO CONTACT:PHONE #:					
	Floor plans of school 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 if applicable?					
	Water supply (public water or well)					
	Plan Review fee & Annual Permit fee paid					
	1 toilet shown on floor plan for every 50 children.					
	Separate restrooms shown on floor plan for boys, girls and faculty.					
	1 sink shown on floor plan for every 50 children.					
	1 water fountain shown on site plan for every 100 children.					
	1 mop sink shown on floor plan.					
Y/N	Y / N Does the school require Physical Education? If yes, show location of showers.					
<u>Y/N</u>	Does the school prepare food for the students or serve catered food? If yes, fill out the appropriate section below.					
Prepared f	ood requires: Catered food requires:					
	Three compartment sink in the kitchen shown on floor plan. Hand wash sink in the area where food is served shown on floor plan.					
	Hand wash sink in the kitchen shown on floor plan.					
Owner Si	gnature & Date Representative					







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Ron DeSantis

Governor

Joseph A. Ladapo, MD, PhD

State Surgeon General

Vision: To be the Healthiest State in the Nation

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, Custo	omers or Seating Capaci	ty:	
Method of Sewage Disposal:	Wa	ter Supply:	
Person to Contact:		Phone #:	
Signature:		Date:	
	For Office U	lse Only	
Date:	_ Pla	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.

Anev	v application is not required for annua	arrenewar unless the information below changes	5.		
NAMI	OF FACILITY				
LOCA	ATION				
	Street	City	State	ZIP Code	
OWN	ER'S NAME	EMAIL ADDRES	EMAIL ADDRESS		
OWN	ER'S ADDRESS_				
01111	Street	City	State	ZIP Code	
OWN	ER'S PHONE	BUSINESS PHONE	BUSINESS PHONE_		
	of Food Service Subtypes				
OCIC	Adult Day Care	Afterschool Meal	Assisted Living	Facility	
	Bar/Lounge	Civic/Fraternal Organization	Crisis Stabilizati	on Unit	
	Detention Facility	Domestic Violence Shelter	Home for Specia	al Services	
	Hospice	Intermediate Care Facility	Migrant Labor C	amp	
	Movie Theater	Prescribed Pediatric Extended Care Center (PPEC)	Recreational Ca	mp	
	Residential Treatment Facility (AHCA)	School	Short Term Residential Treatment (DCF)		
	Transitional Living Facility	Other:			
	d Service Operations				
	Afterschool Meal	Bakery	Boarding School	l	
	Canteen	Caterer	College/Univers	ity Cafeteria	
	Concession Stand	Culinary Education	Deli/Sandwich S		
	Main Operation	Mobile Food Unit	Non-Alcoholic B	severage	
	Restaurant	Retail Food Store	Satellite Kitcher	1	
	School (9 months or less)	School (greater than 9 months)	Temporary Eve	nt Sponsor	
	Temporary Event Vendor	Vending Machine (TCS/PHF)	Other:		
Comr	nent/Special Instructions:				
FOR E	EH USE ONLY: Annual Fee for Your Faci	lity: \$			
Please make check or money order payable to: Florida Department of Health in County.					
accor inforn misre	dance with the requirements of Chap nation contained in this application, w	ative hereby agrees to operate the food establister 381.0072, Florida Statutes, and Chapter 641/hich serves as the basis for licensure, is true areation, or failure to comply with sanitary standar	E-11, Florida Administi nd correct. I understand	ative Code,. The d that any	

Date



STATE OF FLORIDA DEPARTMENT OF HEALTH

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: NewRe	emodel Property Appra	iser Assessed Value	(if remodel): \$		
Printed Name of Property Appraiser:					
Signature of Property Appraiser:			Date:		
Name of Establishment:					
Establishment Address:Street					
Street	City	S	tate ZIP Code		
Owner/Owner's Representative Name & Tit	tle:				
Owner/Owner's Representative Address: _	-				
	Street	City	tate ZIP Code		
Phone Number:	Email:				
Type of Food Service Establishment:					
Bar/Lounge Concession Stand	Detention Facility	Mobile Food Unit	Fraternal/Civic		
Movie Theater School Re	esidential Type Facility (Li	st 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					