



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



**STATE OF FLORIDA**  
**FLORIDA DEPARTMENT OF HEALTH-BROWARD COUNTY**  
**2421 S.W 6 Ave 2<sup>nd</sup> Floor, #240**  
**Fort Lauderdale, FL 33315**  
**954-467-4700 X 4202**

For Office Use Only	
Certificate Number	
<input type="checkbox"/> South	<input type="checkbox"/> North
Date Well Approval	Date Septic Approval

**Plan Review Fee \$140**  
**PLAN REVIEW GUIDE FOR FDOH FOOD REGULATED FACILITIES**

NOTE – Please submit completed plan review guide with plan review fee(s), and supporting documents.

**SECTION 1 – SUPPORTING DOCUMENTS**

Please attach the following documents: <ul style="list-style-type: none"> <li><input type="checkbox"/> 2 sets of floor plans <b><u>DRAWN TO SCALE</u></b> (<u>one set of plans will be kept</u>) showing location of equipment and plumbing fixtures)</li> <li><input type="checkbox"/> Copy of intended menu</li> <li><input type="checkbox"/> Catering contract (*If applicable)</li> <li><input type="checkbox"/> Copy of Division of Corporation</li> <li><input type="checkbox"/> Certificate of Occupancy or proof of approval by local building authority.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Copy of Driver License</li> <li><input type="checkbox"/> If not the register agent: a notarized letter to conduct business on his/her behalf</li> <li><input type="checkbox"/> If renting: copy of lease agreement</li> <li><input type="checkbox"/> Copy of utility bill showing sewer charges or System evaluation signed</li> <li><input type="checkbox"/> Manager's Certification</li> <li><input type="checkbox"/> Fire Inspection</li> </ul>
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**SECTION 2 – PLAN REVIEW TYPE**

Please check the box that best describes your establishment. Please check only one box.

<input type="checkbox"/> Newly Built Establishment	<input type="checkbox"/> New Establishment in Existing Structure	<input type="checkbox"/> Reopen a Closed Establishment	<input type="checkbox"/> Remodeling of Existing Establishment	<input type="checkbox"/> Ownership Change
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**SECTION 3 – TYPE OF ESTABLISHMENT**

Please check the box that best describes your establishment. Check all that apply.

<input type="checkbox"/> Adult Day Care <input type="checkbox"/> After School Meal Program <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Bar/Lounge <input type="checkbox"/> Civic Organization <input type="checkbox"/> Fraternal Organization <input type="checkbox"/> CCFP-Religious Exempt	<input type="checkbox"/> School (9 months or less) <input type="checkbox"/> School (9 months or more) <input type="checkbox"/> Residential Treatment Center (ACHA) <input type="checkbox"/> Short-Term Residential Treatment Center (DCF) <input type="checkbox"/> Transitional Living Facility <input type="checkbox"/> Intermediate Care Facility for Developmental Disabled <input type="checkbox"/> Prescribed Pediatric Extended care Center	<input type="checkbox"/> Domestic Violence Shelter <input type="checkbox"/> Crisis Stabilization Unit <input type="checkbox"/> Detention Facility <input type="checkbox"/> Movie Theater <input type="checkbox"/> Recreational Camp <input type="checkbox"/> Hospice <input type="checkbox"/> Homes for Special Services
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**SECTION 4 – ESTABLISHMENT INFORMATION**

Establishment Name (DBA)	
Location Address	
City	Zip Code (+4 optional)
Phone Number	Fax Number

**SECTION 5 – OWNER INFORMATION**

Note: This address will be where the department will mail all official paperwork

Name (please check one:  Corporation  Partnership  Individual )

First Name	Last Name		
Street Address or Post Office Box			
City	State	Zip Code	
Phone Number	Extension	E-mailed Address	Fax Number
Contact Name <i>(Name of person to contact if there are any questions about the plan review, if different than the owner)</i>			Title (Agent, Architect, etc.)
Phone Number	Extension	E-mailed Address	Fax Number

**SECTION 6 – FOOD OPERATION**

Please check the box that best describes your establishment. Check **all** that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> After School Meal Program      | <input type="checkbox"/> Delicatessens/Sandwich Shop |
| <input type="checkbox"/> Caterer                        | <input type="checkbox"/> Non-Alcoholic Beverage Shop |
| <input type="checkbox"/> Concession Stand               | <input type="checkbox"/> Restaurant-Style            |
| <input type="checkbox"/> Mobile Food Unit               | <input type="checkbox"/> Bakery-type                 |
| <input type="checkbox"/> Satellite Kitchen              | <input type="checkbox"/> Retail Food Store           |
| <input type="checkbox"/> Vending Machine Dispensing PHF | <input type="checkbox"/> Canteen                     |
| <input type="checkbox"/> Main Operation                 |  |

- |  |   |
|--|---|
| <input type="checkbox"/> Full Service  | <input type="checkbox"/> Limited Service (**State Fee exempt) |
| Only catered meals/ <b>No</b> -ware washing/ <b>No</b> -overnight storage/ <b>No</b> -reheating/ <b>No</b> -re-service |   |

Catering Operation  
*\*\*If food is catered from outside sources, the caterer shall be licensed or regulated by a state or federal regulatory food program. When catering is provided as the primary means of food supply, a copy of a current catering agreement shall be provided*

Name of Catering Service	License Number	License Agency(DBPR/DACS/FDOH)
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Describe Food Operation

Will there be service to Highly Susceptible Populations such as Elementary School aged children or younger (birth through 5<sup>th</sup> grade), individuals 60 years or older, and individuals receiving health related and/or custodial care?  Yes  No

Anticipated Construction Completion Date	Anticipated Opening Date	Operating Hours
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Plans/applications submitted to the following authorities on the following dates:

Building _____	Fire Authority _____	Planning _____
Plumbing _____	Zoning _____	Other _____

**SECTION 7 – FINISH MATERIAL**

Please indicate the type of material used in the following areas (e.g., tile, stainless steel, etc.)

**Construction finishes must be smooth, easily cleanable and nonabsorbent.**

	Floor	Walls	Shelving
<b>Food Preparation</b>			
<b>Food Storage</b>			
<b>Dishwashing Area</b>			
<b>Dry Storage Area</b>			

**SECTION 8 – KITCHEN FACILITY DETAILS**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Hand Sinks Quantity _____ | <input type="checkbox"/> 2-compartment sink | <input type="checkbox"/> 3-compartment sink with drain boards or equivalent shelving |
|--|---|--|

- |  |                   |
|--|-------------------|
| <input type="checkbox"/> Prep Sinks Quantity _____ | Mop sink location |
|--|-------------------|

- |  |   |
|--|---|
| <input type="checkbox"/> Residential Dishwasher      | <b>Sanitization Method:</b> <input type="checkbox"/> Chemical <input type="checkbox"/> Heat (Hot Final Rinse) |
| <input type="checkbox"/> Commercial grade Dishwasher |   |

**SECTION 9 – TOILET FACILITIES – SHOW ON PLANS**

	Male	Female	Staff
<b>Number of Toilets</b>			
<b>Number of Urinals</b>			
<b>Number of Hand Sinks</b>			

**SECTION 10-SOLID WASTE DISPOSAL**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Dumpster (Dumpster Pad required with drain and running water) | <input type="checkbox"/> Garbage Cans |
|--|---------------------------------------|

**SECTION 11 – POTABLE WATER****The above name facility/business uses the following water supply (choose one type), and/or complete evaluation** Municipal/Public Water System**Name of Supplier:** Onsite Well System**Permit Number:** Establishment served by a 64E-8, F.A.C., Limited Use Public Water System, DOH Regulated Establishment served by a Florida Safe Water Drinking Act (DEP or DOH) regulated public water system**\*\*SYSTEM EVALUATION RESULT: (This section below normally only completed by FDOH if on a DOH water system)** *Approved* *Denied**Printed Name**Signature**Date***SECTION 12 – WASTEWATER****The above name facility/business uses the following water supply (choose one type), and/or complete evaluation** Municipal/Public Sewer**Name of Supplier:** Septic System (Requires Approval from EH Engineering)

\*\*\*Engineering Section: 954-467-4700 X 4231

**Permit Number:****\*\*SYSTEM EVALUATION RESULT: (This section below normally only completed by FDOH if on a DOH water system)** *Approved* *Denied**Printed Name**Signature**Date***SECTION 13 – OWNER/OPERATOR/AGENT SIGNATURE*****I hereby certify that all the information I have provided is correct. I understand that if I failed to complete the plan review guide or submit the required supporting documents, my plan review will be delayed.****Printed Name**Signature**Title**Date***\*\*\*FOR OFFICE USE ONLY\*\*\******Plans approved with the noted and attached provisions***

Plan Review approved by:

*Date****This facility has met all requirements and is approved to open***

Environmental Specialist (Print)

*Signature**Date****\*\*\*All construction is subject to the provisions of the South Florida Building Code, all local building codes, and any other jurisdictional authorities.*****Final Approval and Inspection*****\*\*\* Approval of your plans means that your plans appear to meet the minimum requirements of the Florida Department of Health. You must make sure that you meet all other requirements that apply. In addition, a **satisfactory pre-opening INSPECTION** by the department and **ISSUANCE** of a **Sanitation Certificate** are required prior to operation or signage of Alcoholic Beverages Papers.***