



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 \_\_\_\_\_



**STATE OF FLORIDA**  
**FLORIDA DEPARTMENT OF HEALTH-BROWARD COUNTY**  
 Environmental Health-2421 S.W 6 Ave 2<sup>nd</sup> Floor  
 Fort Lauderdale, FL 33315  
 954-412-7335

**Plan Review Fee \$140**  
**PLAN REVIEW GUIDE FORM**

For Office Use Only
Certificate Number
Zone Assignment:
Inspector Assigned/Date:

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

**SECTION 1 – SUPPORTING DOCUMENTS**

Please attach the following documents: <input type="checkbox"/> 1 set of floor plans DRAWN TO SCALE with the following specifications (as applicable): <ul style="list-style-type: none"> <li>• Show and label equipment (hot and cold holding units, ovens, stove, etc.)</li> <li>• Label all handwashing sinks.</li> <li>• Label separate food preparation sink.</li> <li>• Label ware washing equipment (3-comp. sink or commercial dishwasher)</li> <li>• Label restrooms, plumbing fixtures (toilets, lavatories)</li> <li>• Label service sink or curbed cleaning facility (mop sink or can wash area)</li> <li>• Label areas used for dry storage.</li> <li>• Label dumpster location, garbage rooms, dining areas</li> </ul>	<input type="checkbox"/> Catering contract (*if applicable) <input type="checkbox"/> Copy of Division of Corporation <input type="checkbox"/> Copy of water utility bill showing sewer charges or if facility is on septic, must complete <b>Section 12</b> on application. <input type="checkbox"/> Manager’s Certification (*If applicable) <a href="http://www.floridahealth.gov/food/manager-certification">Food Manager Certification   Florida Department of Health (floridahealth.gov)</a> <input type="checkbox"/> Fire Inspection <input type="checkbox"/> Certificate of Occupancy from local building authority <input type="checkbox"/> Copy of intended menu
---	---

**SECTION 2 – PLAN REVIEW TYPE**

Please check only one box	
<input type="checkbox"/> Newly built Establishment <input type="checkbox"/> New Food Establishment in Existing Structure <input type="checkbox"/> Reopen a Closed Food Establishment	<input type="checkbox"/> Remodeling of Existing Food Establishment <input type="checkbox"/> Ownership Change <input type="checkbox"/> Change in Level of Food Service

**SECTION 3 – ESTABLISHMENT INFORMATION**

Establishment Name (DBA)	
Location Address	
City	Zip Code (+4 optional)
Mailing Address	
City	Zip Code (+4 optional)
Establishment Phone Number	E-mail Address

**SECTION 4 – OWNER INFORMATION**

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

Name (please check one: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Individual)			
First Name		Last Name	
Street Address or Post Office Box			
City	State	Zip Code	
Phone Number	Extension	E-mail Address	Fax Number
Contact Name			Title (Agent, Architect, etc.)
Phone Number	Extension	E-mail Address	Fax Number

**SECTION 5 – FOOD OPERATION DESCRIPTION**

Please check the box that best describe the type of food service or level of preparation for the establishment. Check **all** that apply.

*\*\*Please note the term TCS foods stands for Time/Temperature control for safety foods.*

- Receipt and service of catered food
- Service of prepackaged non-TCS foods (snacks)
- Beverage Service only (Alcoholic)
- Juice preparation/service
- Ware-washing of equipment
- Washing of fruits and vegetables
- Simple Cooking (also known as cook-serve: product is brought to appropriate cooking temperature and held at safe temperature for same day service only).

- Complex Cooking involving raw ingredients and retention of leftovers.
- Specialized Processing-Type Activities (such as acidification, cook-chill, reduced oxygen packaging, smoking, sous vide etc.)
- Major Cooling (cooling for purpose of overnight storage of food and subsequent reheating)
- Minor Cooling (cooling for use in subsequent service on the same day)
- Consumption of raw food (such as sushi or partially cooked meats)
- Reheating of TCS foods (microwave, stove, oven)
- Hot holding of TCS foods

Does the facility receive bulk meals?

- Yes
- No

Does the facility retain TCS food items overnight?

- Yes
- No

Name of Catering Company (\*\*if catering food)

License Number

License Agency (DBPR/DACS/FDOH)

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

Operating Times/Meal Service Times:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Opening Time							
Meal Service Times	Snack	Breakfast		Lunch		Dinner	

**SECTION 6 – FINISH MATERIAL**

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

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

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

**SECTION 7 –KITCHEN OR PREPARATION AREA DETAILS**

Hand Sinks Quantity \_\_\_\_\_

2-compartment sink  
Quantity \_\_\_\_\_

Hot Holding Equipment Type:

Prep Sinks Quantity \_\_\_\_\_

Mop sink location

- Residential Dishwasher
- Commercial grade Dishwasher
- 3 Compartment sink with drainboards

**Sanitization Method:**  Chemical  Heat (Hot Final Rinse)

**SECTION 8 – TOILET FACILITIES**

Number of bathrooms	Public	Employee	Unisex	Total

**SECTION 9-SOLID WASTE DISPOSAL**

Dumpster (Dumpster Pad required with drain and running water)

Garbage Cans

**SECTION 11 – POTABLE WATER****The above name facility/business uses the following water supply (choose one type):** Municipal/Public Water System

Name of Supplier:

 Onsite Well System (Requires approval from the Department of Health)

\*\* Contact the Department of Health-Environmental Engineering Section at 954-412-7334

**\*\*Onsite Well System or Limited Use System Approval: (This section is to be completed by the Florida Department of Health)** 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 Approved Denied

Permit Number:

DOH Employee Name

Signature

Date

**SECTION 12 – WASTEWATER****The above name facility/business uses the following water supply (choose one type):** Municipal/Public Sewer

Name of Supplier:

 Septic System (Requires Approval from the Department of Health)

\*Contact the Department of Health-Environmental Engineering Section at 954-412-7534

**\*\*Septic System Approval (This section is to be completed by the Florida Department of Health for Septic Systems only)** Approved Denied

Permit Number:

DOH Employee 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.**