ORANGE COUNTY HEALTH DEPARTMENT PLANS REVIEW ROUTING SHEET

DATE: __________________ ________ **(Official Use Only) PLANS ROUTING NUMBER:** ______________________

PAYMENT TYPE: _________ ________ **AMOUNT: $**________ ____ **CHECK NUMBER:** ________________

Please note, the fee for plan review is $53 per hour. If your plan review requires additional time or requires revisions, you will be charged an additional $53 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 #:**________________________

COMMENTS:____

FOR OFFICE USE ONLY

UTILITY REVIEWER:__________________________________ **DATE:**_______________________________

REMARKS: ____ **APPROVAL STAMP**

____

____

____

____ **SIGNATURE:**_________________________

FACILITY REVIEWER:_________________________________ **DATE:**__________ ___________________

REMARKS:____ _______________

____ _______________

____ **SIGNATURE:**_______ __________________