

**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

**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: \_\_\_\_\_