

APPLICATION FOR PLAN REVIEW
 (Please type or print in blue or black ink)

ESTABLISHMENT NAME (dba):		CHECK IF APPLICABLE:			
		<input type="checkbox"/> BLDG PERMIT APPLICATION SIGN-OFF REQUIRED <input type="checkbox"/> PRELIMINARY LIQUOR DISPENSER APPROVAL ONLY			
ESTABLISHMENT LOCATION ADDRESS:			TAX MAP KEY		
STREET:			ZONE	SECTION	PLAT
CITY: _____ ZIP CODE: _____					
OWNER NAME (Corp., LLC, Partnership, Sole Owner, Other):					
CONTACT PERSON:			CONTACT PHONE NO.:		
I understand that approval of the submitted plan is contingent upon compliance with the requirements of Hawaii Administrative Rules, Title 11, Department of Health.					
DATE _____		SIGNATURE OF OWNER/AGENT WITH AUTHORITY _____			
PHONE # OF OWNER/AGENT WITH AUTHORITY _____		PRINT NAME _____		TITLE _____	
OWNER/AGENT MAILING ADDRESS:					
STREET:					
CITY: _____		STATE: _____		ZIP CODE: _____	
(OFFICIAL USE ONLY) FEE AMOUNT: (Circle One) (NON REFUNDABLE)					
		Food Establishment	\$200	\$300	No Fee
		Swimming Pool	\$200		
Payable to: STATE OF HAWAII					
Submit application and fee to:		SANITATION BRANCH 79-1015 HAUKAPILA STREET KEALAKEKUA, HI 96750			
(FOR OFFICIAL USE ONLY) COMMENTS (Continue on back):					

I have been informed and received a copy of the deficiencies listed above that must be corrected before plan approval.

Signature of owner/agent _____ Print name _____ Date _____

SECTION BELOW FOR OFFICIAL DEPARTMENT OF HEALTH USE ONLY

Fee Paid	Date Paid	Method of Payment	Receipt No.	Received By
PLAN RECEIVED BY: NAME: _____ DATE: _____ REFERRED TO: _____				
PLAN PICKED UP FOR REVISION: NAME: _____ DATE: _____ DATE RESUBMITTED: _____				
PERSON NOTIFIED OF PLAN APPROVAL: NAME: _____ DATE: _____				
APPROVED BY: _____		Signature of Agent/Dept. of Health _____		
Date				