SANITATION BRANCH
99-945 HALAWA VALLEY STREET
AIEA, HAWAII 96701
TELEPHONE NUMBER: (808) 586-8000 FAX: (808) 586-8040

STATE OF HAWAII
DEPARTMENT OF HEALTH
www.health.hawaii.gov

APPLICATION FOR PLAN REVIEW

(Please type or print in blue or black ink)

ESTABLISHMENT NAME (dba):	**CHECK IF APPLICABLE:** **( ) BLDG PERMIT APPLICATION SIGN-OFF REQUIRED** **( ) PRELIMINARY LIQUOR DISPENSER APPROVAL ONLY**

ESTABLISHMENT LOCATION ADDRESS:	**TAX MAP KEY**			
STREET:	ZONE	SECTION	PLAT	PARCEL
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**
99-945 HALAWA VALLEY STREET
AIEA, HI 96701

THERE WILL BE A SERVICE FEE OF $25.00 FOR ANY CHECK DISHONORED BY THE BANK.

(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: _____ _____
Date Signature of Agent/Dept. of Health

PERMIT NO.: _____